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# AIDS in Probation and Parole

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U.S. Department of Justice
**National Institute of Justice**
*Office of Communication and Research Utilization*

# AIDS in Probation and Parole

**by**

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*Issues and Practices in Criminal Justice* is a publication series of the National Institute of Justice. Designed for the criminal justice professional, each *Issues and Practices* report presents the program options and management issues in a topic area, based on a review of research and evaluation findings, operational experience, and expert opinion on the subject. The intent is to provide criminal justice managers and administrators with the information to make informed choices in planning, implementing and improving programs and practice.

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# FOREWORD

Acquired Immunodeficiency Syndrome, or AIDS, is one of the most urgent public health issues of our time. It is a deadly disease. The outlook for vaccines or cures is uncertain. And there are significant problems and costs associated with treatment.

This public health issue has particular ramifications for the criminal justice system. Many offenders are or have been IV drug users and are thus at risk for contracting and transmitting the disease. To help minimize this risk, the National Institute of Justice has since 1985 conducted a series of studies to assist criminal justice agencies in developing sound and appropriate policies and procedures for dealing with AIDS and HIV infection.

For community corrections services, AIDS presents unique problems. The dilemma is how to develop effective and equitable polices that serve the rights and needs of HIV-infected offenders, but also protect the larger community in which the offenders are supervised and address the concerns and safety of correctional staff. Community corrections administrators face tough decisions about disclosure of HIV status information, education and prevention, and costs of care and treatment – a task made more difficult by expanding caseloads and limited budgets.

This report responds to the needs of community corrections agencies. It reviews up-to-date medical and legal information and offers guidelines and examples of policies and strategies for dealing with AIDS in probation and parole services. It represents not only the work of the authors, but also the cooperation and assistance of numerous professionals in the fields of community corrections and medicine. No single course of action is prescribed. Rather, the report discusses the range of AIDS policies and practices in operation across the country and examines the advantages and disadvantages of different approaches. In addition, the report presents the basic facts about AIDS – how it is transmitted, how it can be prevented, and its impact on probation and parole agencies.

The National Institute of Justice hopes that community corrections professionals will find this information useful in developing education, training, and effective management programs to counteract the threat of AIDS.

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# Introduction: PURPOSE AND CONTENTS OF THE REPORT

Since it was identified nearly a decade ago, the deadly disease known as AIDS, or acquired immunodeficiency syndrome, has garnered unprecedented attention in the United States and around the world. Recognized first in this country among homosexual and bisexual men, the virus spread rapidly through the intravenous drug-using community through sexual activity and the sharing of injection equipment. With nearly 80,000 cases reported to date,[1] it is estimated that more than 270,000 cases will have been diagnosed by 1991.[2]

While the media have occasionally reported on AIDS in prison populations, little attention has been devoted to the unique problems faced by HIV-infected persons leaving prison, or on probation or parole. Nor has attention focused on the special issues faced by their supervising agencies and line officers. In order to address the concerns of these two groups, the National Institute of Justice has sponsored this report.

## Goals of the Report

The management of persons with HIV-related conditions is a complex matter for community corrections personnel. These cases raise a series of medical, logistical, ethical, legal, and safety-related questions.

- How should both staff and clients be educated about AIDS?
- What training should staff receive?
- How can the risk of exposure to the disease or actual transmission of the virus be minimized?
- How can unreasonable fears be minimized?
- When, if at all, is it appropriate to test probationers and parolees for AIDS?
- How should confidentiality be maintained if testing takes place?
- What are the costs, financial and other, of education and of testing?
- What are the legal parameters of supervision?

There is no single answer to many of these questions. Different jurisdictions may choose different policies to address specific local conditions and priorities. To inform these decisions, this report draws on the most up-to-date information available, and includes both guidelines for developing individual policies and examples of policies already in place in certain jurisdictions.

The early part of this report provides a brief but in-depth overview of the medical history and epidemiology of AIDS. The last several chapters provide specific guidelines for formulating testing policies, developing education and training programs, and dealing with confidentiality and related legal issues. Thus the areas covered in this report include:

- medical definition of AIDS, and how it is transmitted
- epidemiology of AIDS: in the U.S., and in probation and parole populations
- testing for AIDS, and the issues it raises
- education and training
- confidentiality, legal, and labor relations issues

It is hoped that with the significant issues identified, and with pertinent information supplied about both general concerns and specific solutions, this report will help each agency to develop effective AIDS policies.

## Sources of Information

This report is based on information from the following sources:

- materials received from 68 probation agencies, of which 42 are administered through a central state agency and 26 are county or regional systems;
- materials received from 47 parole agencies, of which 45 are central state agencies and two are county systems;
- discussions with community corrections personnel; and
- an extensive review of pertinent literature.

Information was requested from every state's probation and parole agencies. In states where probation or parole is administered by region or county, a sample of regional or county agencies was contacted.

List of all the probation and parole agencies which responded are provided in Appendix A.

Our primary interest was in determining numbers of AIDS cases under supervision in each agency, definitions currently used by agencies to identify AIDS or ARC, and any policies the agencies had formed or were forming in such areas as education, training, safety precautions, liability, and disclosure. Information was also requested on legal issues or cases encountered, and concerns about AIDS case management.

The request made clear that no data obtained about the incidence of AIDS in corrections populations (numbers of current cases), would be reported according to state or jurisdiction. Instead, all reporting of incidence figures is organized by region or area, rather than state or county. Any other information in this report containing state-based incidence data—whether in correctional facilities or in the general population—comes from other published sources. On the other hand, we did request permission to identify states or jurisdictions in connection with descriptions of any specific policies, procedures, or other useful information. Respondents could answer with permission, with qualified permission, or could request anonymity. In the last case the authors promised not to link any specific information to the state or jurisdiction anywhere in the document.

In some cases, we clarified confusing or evocative responses with phone conversations. We also asked agencies to provide any written policy and any education and/or training materials they currently used, some of which are included in the Appendices. All questionnaires were coded and analyzed using the microcomputer versions of the Statistical Package for the Social Sciences (SPSS/PC). All data are current as of November 15, 1987 through March 1, 1988, the period during which the questionnaires were answered.

In addition to the survey results, the project draws on the growing body of AIDS literature and related topics, in fields as varied as education, medicine, public health, and general-interest media. The author also drew on national data bases, as well as on the expertise of medical and legal experts and corrections personnel.

## NOTES

1. Centers for Disease Control, *AIDS Weekly Surveillance Report* November 14, 1988.
2. Institute of Medicine, National Academy of Sciences, *Confronting AIDS: Directions for Public Health, Health Care, and Research* (Washington, D.C., 1988), p. 57.

# AIDS IN PROBATION AND PAROLE

# Chapter 1: THE CAUSES OF AIDS AND ITS TRANSMISSION

AIDS, or Acquired Immunodeficiency Syndrome, is a condition in which the immune system becomes so compromised that the individual is unable to fight off a host of infections. It was first identified in 1981 among previously healthy homosexual or bisexual men in New York and San Francisco, although it has been found in banked blood of IV drug users in New York donated as early as 1978.[1] The first cases involved a rare form of bacterial pneumonia (*Pneumocystis carinii* pneumonia), or a type of skin cancer (Kaposi's sarcoma), which had previously been seen only in a far less virulent form among elderly men of eastern European or Mediterranean origins. In the absence of other causes, the appearance of these rare diseases pointed to an underlying problem with the immune system. Those affected were simply unable to fight off infection naturally and, often after a series of illness episodes, died. In addition to these two diseases, identified early in the epidemic, persons with AIDS may also suffer from a wide range of "opportunistic infections." These infections, often from common viral or bacterial sources, are not life-threatening in a healthy individual but become deadly in persons with seriously compromised immune systems.

The diagnosis of AIDS involves the appearance of one of the known AIDS-related diseases and clinical evaluation of severe immune suppression unrelated to other factors (such as chemotherapy). The Centers for Disease Control's guidelines for the diagnosis of AIDS can be found in Appendix B. Since AIDS was first recognized, New York City reports an unusually high incidence of fatalities from diseases such as bacterial endocarditis, non-pneumocystic pneumonia and tuberculosis among intravenous drug users,[2] leading to speculation about the specific role of the AIDS virus in other diseases as well. As information develops, these or other diseases may be added to the CDC definition.

There are a number of "indicator diseases" associated with AIDS. The anomalous presence of one or more of them helps to identify AIDS. For example, some diseases are often not seen in a given age group, such as Kaposi's sarcoma or severe candidiasis ("thrush"). Others are not typically found in the organ affected, such as cytomegalovirus or tuberculosis in areas other than the lung. Some are even diseases not usually manifested in humans. The AIDS virus may also produce encephalopathy or "AIDS dementia," which involves increasing neurological problems, or a condition known as HIV "wasting syndrome," involving uncontrolled weight loss and deterioration.

The name "AIDS" is really an umbrella term, referring to a syndrome, or a group of diseases caused by a virus. Moreover, it actually refers to the end state of the illness. Some persons infected with the virus may remain asymptomatic for many years, perhaps indefinitely. Others progress from infection to a condition known as AIDS-Related Complex (ARC), a milder condition characterized by weight loss, swollen lymph glands, continuous or intermittent diarrhea and fever, severe fatigue and tests indicating immune suppression. It is only recently, in fact, that scientists have argued that ARC should be considered an early form of AIDS, rather than a separate complex or condition. From ARC, patients usually progress to full-blown manifestation of the disease. In the end state, the individual has marked laboratory indications of immune suppression and has developed one or more of the indicator diseases associated with the syndrome.

However, AIDS does not always mean an orderly progression to an end state, as the definition might imply. Persons may become infected and quickly develop the end stage of the illness. Others may never progress beyond ARC symptoms. What determines the rate or sequence of progression is the subject of current investigation. It is believed, though, that AIDS is nearly always fatal. Of the 80,000 cases of AIDS diagnosed since June of 1981, 56 percent have died. In the early stages of the epidemic, life expectancy for a person diagnosed with AIDS was approximately two years. Due to the development of life-extending treatments, patients may live as long as five or more years after diagnosis.[3] Expectancy nationwide also varies with a number of co-factors, which are discussed in the next section.

## What Causes AIDS?

AIDS is caused by a virus generally known as the Human Immunodeficiency Virus (HIV), a human retrovirus which was discovered by scientists at the Institute Pasteur in Paris and further defined by Dr. Robert Gallo and his associates at the National Institutes of Health in 1983 and 1984. The virus infects certain white blood cells known as T-4 cells, rendering them incapable of combating infections. Once the virus has entered a host cell, it may remain dormant for long periods of time. When stimulated into action, though, the virus reproduces rapidly, causing the depletion of T-4 cells that is the hallmark of AIDS diagnoses, and thus leaving the individual vulnerable to a number of opportunistic infections which would not normally harm a healthy person.

It is not known definitely what stimulates the dormant virus into activity. However, it is believed that a number of "co-factors" influence one's susceptibility to the development of AIDS once exposed: continued high-risk behaviors such as intravenous drug use, poor nutrition, alcohol and drug consumption, and continued unprotected sexual contact with infected persons; additional infections such as hepatitis B or cytomegalovirus; and genetic predisposition.[4] Research continues on the co-factors involved with AIDS, but the exact role they play is as yet unknown. A factor such as heavy alcohol use, for example, may act as a catalyst for HIV action or may simply further suppress the immune system.

## Exposure, Seroconversion and Manifestation of AIDS Symptoms

It is important to distinguish among the various stages of HIV-related illness and to understand their relationships to one another. Exposure to the virus, for example, does not guarantee infection, and infection does not necessarily cause symptoms to appear.

Exposure means that the person has had high-risk contact with someone infected with the AIDS virus, which may have resulted in his or her own infection. The ratio of exposure to actual infection is not known. However, research with homosexuals and intravenous drug users indicates that those who engage in high-risk activities frequently and with multiple partners are the most likely to become infected.

Tests are usually done in series, consisting of an "ELISA test," which is repeated if positive, and a confirmatory "Western Blot test." These are discussed in Chapter 3. Figure 1.1 explains the relationships among exposure, infection, HIV seropositivity, ARC, and AIDS.

The term "seropositivity" refers to a positive test result, indicating a person's infection with the virus. All of the standard tests, it is crucial to note, detect *antibodies* to the virus in the blood of those infected, not the virus itself. Thus an infected individual is accurately referred to as "HIV antibody-positive," or alternately, seropositive. Moreover, since seropositivity refers to infection, the progression from exposure to infection is known as "seroconversion." As was discussed, seropositivity does not imply current or active illness. But it is generally agreed that seropositivity *does* indicate the ability to transmit the virus to others.

One factor which may complicate the identification of a particular stage is the "window," or period time between exposure and development of antibodies or subsequent detectable infection. This window, or time to conversion, may not occur for as long as weeks or even months after exposure.[5] Thus, an infected person may test negative because antibodies to the virus have not yet developed, but in this critical period, the individual would still be able to transmit the virus. For this reason, tests should be repeated up to six months after exposure to ensure the validity of the results.

There is limited evidence as to the amount of the virus and/or the number of exposures required for infection to occur. There is also limited evidence as to the amount of the virus or the number of exposures required to transmit infection. It does appear that a large dose of tainted blood given intravenously, as occurs during a blood transfusion, poses an extremely high risk; small doses, as with an accidental needle stick, pose a fairly small one. On the other hand, repeated exposure even to small amounts of blood or other body fluid, as with intravenous drug use involving shared needles, ultimately will present a serious risk.[6]

There also appears to be a relationship between continued exposure and development of the disease. In studies of HIV-infected intravenous drug users in New York, the best predictor of manifestation of the disease is continued intravenous use of drugs.[7] This may be related to continued assaults on the immune system, lessening its ability to combat the virus, or to the accumulation of active virus in the system.

The number of seropositive persons who will eventually manifest the disease is unknown. It is believed, however, based on data gathered by tracking infected persons, that the majority of those infected will eventually develop AIDS. The National Academy of Science estimates that 25-50 percent of HIV seropositives will develop AIDS within five to 10 years of infection and that 90 percent of seropositives will show some immune system deficiency within five years of seroconversion.[8]

One of the difficult aspects of AIDS for epidemiological study is the long incubation period of the disease, or the long time between infection and the appearance of symptoms. In most cases the incubation period ranges from two and a half to five years, although there are reported cases of incubation as long as eight or 10 years.[9] This long period of uncertainty presents some of the most difficult problems for managing infected persons and for estimating sero-

Figure 1.1

## RELATIONSHIPS AMONG EXPOSURE, INFECTION, HIV SEROPOSITIVITY, ARC, AND AIDS

| Stage | Meaning | Relationship to Previous Stage(s) |
|---|---|---|
| Exposure | Individual has contact with HIV in a way that makes transmission possible (e.g., sexual contact or needle-sharing activity). | --- |
| Infection | Individual is infected with HIV. Infection is assumed to be permanent. | Unknown, although multiple exposures probably increase the risk of infection. |
| Seropositivity | Individual has antibodies to HIV, meaning that infection has occurred at some some time in the past. Antibody tests cannot pinpoint date of infection. It usually takes 3-12 weeks from the time of infection for the antibodies to appear, although lag-times significantly longer have been reported. | CDC considers double ELISA test confirmed with a Western Blot to be an accurate indicator of infection status; however, there continues to be concern about false positives, particularly in populations with a low prevalence of infection |
| ARC | Presence of a combination of conditions together giving evidence of symptomatic infection with HIV. (Note: New CDC definition of AIDS incorporates many individuals previously classified as ARC patients). | National Academy of Sciences estimates that 90% of seropositive individuals show some immunodeficiency within 5 years. |
| AIDS | Illness characterized by one or more "indicator diseases" listed by CDC. | It is generally believed that at least one-half of seropositive individuals and individuals with ARC will develop AIDS. However, all estimates are uncertain due to the lengthy incubation period. |

Source: T.M. Hammett, Aids in Correctional Facilities: Issues and Options, Third Edition, (Washington, D.C.: National Institute of Justice, U.S. Department of Justice, 1988).

prevalence, or prevalence of seropositivity in a given population. Persons who are infected may not know they are HIV-infected until symptoms of illness appear. Persons who are aware of their HIV antibody-positive status, but are otherwise healthy, may spend many anxious years anticipating and fearing the appearance of symptoms.

While AIDS is believed to be universally fatal, survival time varies in length according to the particular illness manifested, and to genetic factors, the availability of treatment, and the general health of the patient. Figure 1.2 indicates the rates of survival by year of diagnosis. As this figure shows, fatality for cases diagnosed in 1981 is over 90 percent. Survival after the first year of diagnosis also varies considerably with the specific illness contracted. Persons who develop Kaposi's sarcoma seem to survive almost twice as long as those with *Pneumocystis carinii* pneumonia, though short-term survival with this disease is improving.[10] Factors such as concurrent intravenous drug use also influence the length of survival. Intravenous drug users, for example, are more likely to contract *Pneumocystis* and/or opportunistic infections, are more likely to continue high-risk activity, and are more likely to have both poor nutrition and health care.

## How is the AIDS Virus Transmitted?

While a great deal of media attention has been paid to AIDS, the question paramount in the public's mind, "Can someone give it to me?," is still not adequately understood by a great number of people. A survey conducted by the United States Public Health Service's Weekly National Health Interview revealed that a number of people still think AIDS can be transmitted through sharing kitchen utensils, from public toilets or by donating blood.[11]

There are three known methods of transmission of the virus: sexual contact, inoculation with blood, and perinatal events. The latter term refers to pregnancy and childbirth, and may include breast-feeding. Empirical evidence from the CDC and other sources speaks strongly against the probability of transmission through body fluids other than blood, semen, vaginal secretions, and breast milk. In the 10 years of the AIDS epidemic, there have been no documented cases of transmission through any other sources.

Moreover, studies of over 14,000 persons with AIDS have found no cases of transmission to family members through non-sexual casual contact. These findings hold true even in the case of children or infants with AIDS where daily contact with urine, tears and saliva is part of the care of the child.[12]

Since the epidemic began, epidemiologists have carefully tracked all cases, and the three known routes outlined have remained the only means of transmission identified. With almost 75,000 cases of AIDS and many more ARC and seropositivity data, the consistency of these findings is extremely compelling. Except for a small number of cases lost to follow-up, all known cases of AIDS can be attributed to one of the three methods of transmission. Figure 1.3 summarizes the risk of infection through the various transmission modes.

As the data indicate, transmission of HIV is difficult and does not occur through casual contact. Though it is a blood-borne disease like hepatitis B, HIV is far more difficult to transmit than hepatitis B,[13] and precautions or clean-up procedures developed for hepatitis B are more than adequate for dealing with the AIDS virus.

The following sections briefly describe the three known transmission modes:

- transmission through inoculation with blood
- transmission through sexual contact
- perinatal transmission

### Transmission through Inoculation with Blood or Blood Products

There are four instances in which contaminated or HIV-infected blood is inoculated into a non-infected person, making transmission of HIV possible:

1. injection of the blood of someone else during sharing of intravenous drug use equipment;
2. transmission during transfusion with contaminated blood or blood products;
3. transmission through accidental needlesticks with contaminated needles; and
4. transmission through an open wound or mucous membrane exposure.

#### *1. Transmission through intravenous drug use*

Transmission which occurs during sharing of intravenous drug use equipment is the most common method of transmission by inoculation. Eighteen percent of all AIDS cases in this country come from this source. In areas of high incidence of intravenous drug use, the numbers are even higher. For example, in New York and northern New Jersey, almost 50 percent of all AIDS cases are found among intravenous drug

Figure 1.2

BREAKDOWN OF AIDS SURVIVAL RATES IN THE U.S.
BY YEAR OF DIAGNOSIS

| | | NUMBER OF CASES | NUMBER OF KNOWN DEATHS[1] | CASE-FATALITY RATE |
|---|---|---|---|---|
| 1981 | Jan-June | 89 | 82 | 92% |
| | July-Dec | 181 | 168 | 93% |
| 1982 | Jan-June | 368 | 326 | 89% |
| | July-Dec | 655 | 577 | 88% |
| 1983 | Jan-June | 1238 | 1112 | 90% |
| | July-Dec | 1608 | 1429 | 89% |
| 1984 | Jan-June | 2501 | 2064 | 83% |
| | July-Dec | 3258 | 2670 | 82% |
| 1985 | Jan-June | 4536 | 3586 | 79% |
| | July-Dec | 5846 | 4379 | 75% |
| 1986 | Jan-June | 7361 | 4963 | 67% |
| | July-Dec | 8675 | 4723 | 54% |
| 1987 | Jan-June | 10306 | 4394 | 43% |
| | July-Dec | 10534 | 3008 | 29% |
| 1988 | Jan-May 02 | 3620 | 542 | 15% |
| TOTAL[2] | | 60852 | 34088 | 56% |

[1] Reporting of deaths is incomplete.

[2] Table totals include 76 cases diagnosed prior to 1981. Of these 76 cases, 65 are known to have died.

Source: CDC, AIDS Weekly Surveillance Report - United States, May 2, 1988.

Figure 1.3

BREAKDOWN OF TOTAL AIDS CASES IN THE U.S.
BY TRANSMISSION FREQUENCY

| TRANSMISSION CATEGORIES[1] | Year Ending MAY 2, 1987 | | Year Ending MAY 2, 1988 | | CUMULATIVE CASES AND DEATHS SINCE JUNE 1981 | | | |
|---|---|---|---|---|---|---|---|---|
| ADULTS/ADOLESCENTS | Number | (%) | Number | (%) | Number | (%) | Deaths | (% Cases) |
| Homosexual/Bisexual Male | 9949 | ( 66.1) | 14990 | ( 60.0) | 37999 | ( 63.4) | 21010 | ( 62.7) |
| Intravenous (IV) Drug Abuser | 2446 | ( 16.3) | 5113 | ( 20.5) | 11045 | ( 18.4) | 6203 | ( 18.5) |
| Homosexual Male and IV Drug Abuser | 1081 | ( 7.2) | 1752 | ( 7.0) | 4438 | ( 7.4) | 2637 | ( 7.9) |
| Hemophilia/Coagulation Disorder | 166 | ( 1.1) | 256 | ( 1.0) | 591 | ( 1.0) | 349 | ( 1.0) |
| Heterosexual Cases[2] | 615 | ( 4.1) | 1072 | ( 4.3) | 2463 | ( 4.1) | 1320 | ( 3.9) |
| Transfusion, Blood/Components | 386 | ( 2.6) | 752 | ( 3.0) | 1467 | ( 2.4) | 988 | ( 2.9) |
| Undetermined[3] | 402 | ( 2.7) | 1038 | ( 4.2) | 1894 | ( 3.2) | 1027 | ( 3.1) |
| SUBTOTAL | 15045 | (100.0) | 24973 | (100.0) | 59897 | (100.0) | 33534 | (100.0) |
| CHILDREN[4] | | | | | | | | |
| Hemophilia/Coagulation Disorder | 14 | ( 6.3) | 26 | ( 5.9) | 53 | ( 5.5) | 32 | ( 5.8) |
| Parent with/at risk of AIDS[5] | 181 | ( 80.8) | 329 | ( 74.9) | 735 | ( 77.0) | 422 | (76.2) |
| Transfusion, Blood/Components | 22 | ( 9.8) | 63 | ( 14.4) | 131 | ( 13.7) | 79 | ( 14.3) |
| Undetermined[3] | 7 | ( 3.1) | 21 | ( 4.8) | 36 | ( 3.8) | 21 | ( 3.8) |
| SUBTOTAL | 224 | (100.0) | 439 | (100.0) | 955 | (100.0) | 554 | (100.0) |
| TOTAL | 15269 | | 25412 | | 60852 | | 34088 | |

[1] Cases with more than one risk factor other than the combinations listed in the tables or footnotes are tabulated only in the category listed first.

[2] Includes 1460 persons (321 men, 1139 women) who have had heterosexual contact with a person with AIDS or at risk for AIDS and 1003 persons (780 men, 223 women) without other identified risks who were born in countries in which heterosexual transmission is believed to play a major role, although precise means of transmission have not yet been fully defined.

[3] Includes patients on whom risk information is incomplete (due to death, refusal to be interviewed, or loss to follow-up), patients still under investigation, men reported only to have had heterosexual contact with a prostitute, and interviewed patients for whom no specific risk was identified; also includes one health-care worker who seroconverted to HIV and developed AIDS after documented needlestick to blood.

[4] Includes all patients under 13 years of age at time of diagnosis.

[5] Epidemiologic data suggest transmission from an infected mother to her fetus or infant during the perinatal period.

Source: CDC, AIDS Weekly Surveillance Report - United States, May 2, 1988.

users. The cases in this region constitute almost 75 percent of the nation's total IV drug-related AIDS cases.[14]

The AIDS virus is spread among intravenous users through sharing the needles, syringes and heating elements ("cookers") used in injection. Users traditionally will draw their own blood up into the syringe to mix with the dissolved drug and re-inject it into their veins, in order to use all traces of the drug mixture. The next user will continue in the same way, but will inject any traces of blood remaining from the previous user, as well as his own blood with his drug injection. Since needles are only cleaned in the most perfunctory way—traditionally this means only blowing into the needle or manually clearing a clogged tip of the hypodermic with a wire—traces of the prior user's blood remain in the equipment. When a needle is shared among many users, as is often the case, the possibility of HIV infection is multiplied again and again.

Sharing equipment is common. A study in San Francisco indicates that 90 percent of addicts reported that they had shared needles with an average of 37 different people in the prior year,[15] and a New York/New Jersey study found that one-third of users reported sharing daily.[16] Data from the Drug Use Forecasting System (DUF) indicates that almost half of all drug injectors arrested in Los Angeles report that they currently share needles with one or more people;[17] other cities report lower incidence of sharing, 20 to 25 percent. DUF, a program sponsored by the National Institute of Justice, conducts voluntary and anonymous urine screening of male and female arrestees nationally every three months. Differences found across the country may be attributable to changes in the behavior of addicts in response to AIDS, or to basic regional differences in the drug culture.

Why do users share equipment? There are several reasons. First, initiation into drug use is often the occasion for sharing "works." New IV users are unlikely to have their own injection equipment, as initiation is not generally a planned event. Consequently, they are most often "turned on" with friends who share their equipment with them.

Second, sharing "works" with a "running partner," a friend or a spouse, is a common feature of the drug-use world. Sharing is seen in this context as a social activity, a sign of trust and friendship as well as a convenience. Only one party need carry the equipment when both go to buy and use drugs. And both parties may share the drugs purchased by pooling them into the same "cooker" and into the same syringe. Researchers have found that failure to share can be seen as a serious sign of mistrust or disloyalty among IV users and a serious breach of drug world etiquette.[18]

Sharing needles may also be a convenience if equipment is scarce. While only 12 states make possession of a hypodermic needle a punishable offense, they are in many cases the states in which IV drug use is very common. Addicts may share or rent "works" because they have no access to their own or because they do not wish to be caught with the equipment in their possession. This is the underlying motivation for the use of shooting galleries. Shooting galleries can vary from highly commercial operations, such as those found in New York City, to the more prevalent informal renting of works done by other users in their apartments or in areas where drugs are bought. In a shooting gallery or similar place, a set or several sets of works are rented out to users so that they can use their drugs quickly and leave the area.

For the obvious reasons, the spread of HIV has been linked to the use of shooting galleries or similar operations. It is clear that the more one injects drugs, and consequently the more one is likely to rent, borrow, or share contaminated works, the more likely one is to become infected.

### 2. *Transmission during transfusion*

HIV infection can also occur when contaminated blood or blood products such as plasma are administered to a patient. Since the blood supply has been screened for the presence of HIV since 1985, the number of cases from this source has been dramatically reduced. Only 3 percent of the total AIDS cases reported since 1981 have come from this source, and the majority of these cases stem from infection prior to 1985. The CDC estimates that only about 100 transfusion-associated infections will occur annually out of a total of 16 million units of blood transfused, and the National Academy of Sciences estimates that the risk of transfusion infection is less than 1 in 34,000 for those receiving packed red blood cells.[19]

### 3. *Transmission through accidental needle sticks*

The fear of accidental puncture with a contaminated needle causes great concern among both health care workers and correctional personnel who worry that they may inadvertently come into contact with a needle used by an HIV antibody-positive individual through routine delivery of care, or during law enforcement procedures such as pat-downs or searches. While at first glance the risk of infection through accidental puncture seems similar to that of needle sharing among IV users, there are important differences. First, in the case of IV drug use, blood is thoroughly mixed with drugs and possibly with contaminated blood before the injection. In the case of a needle stick, the infected traces of blood are not thoroughly blended with the second person's blood and in most cases enter only under the skin rather than intravenously, reducing the likelihood of transmission. Second, IV drug users share contaminated needles repeatedly, multiplying the risk of transmission, while the accidental needle stick is a solitary risk event.

For these reasons, the number of transmissions from accidental needle sticks has been very small. In studies of 887 health care workers who have received needle sticks or puncture wounds from HIV-contaminated needles, only four have been infected as a result.[20] These data strongly suggest that, while not an impossible event, infection from these sources is not common.

### 4. *Transmission through an open wound or mucous membrane exposure*

Exposure through contact with certain contaminated mucosa (eyes, nose, mouth) is also of concern to those working closely with or caring for HIV-infected persons. Fortunately, transmission from this source is even less likely than transmission from accidental needlesticks. In CDC studies of health care workers who have had open wounds or mucous membrane exposure to infected patients, no cases of transmission have appeared. There are four instances reported in the literature, however, which have involved open wound or mucous membrane exposure to contaminated blood.

In these cases, all four of whom were health care workers, the individuals became infected after direct contact between HIV-infected blood of a patient and their own broken skin or mucosa.[21] In the first instance, a health care worker with seriously chapped hands came into direct contact with the blood of an

HIV-infected patient for 20 minutes. In the second case, an individual using a high-speed centrifuge spilled HIV-contaminated blood over ungloved hands and forearms. In the third case, a health care worker was splashed with infected blood in the face and mouth. In the last case, a laboratory researcher became infected after regular and extended contact with concentrated preparations of the virus. It is believed that in the course of the work, an incident of unprotected contact occurred between the preparations and the researcher's broken skin or mucosa.

It should be emphasized that these instances might all have been prevented had precautions been taken—gloves, masks, covering broken skin. In the many laboratory situations across the country where staff are working daily with HIV, often in highly concentrated forms, and in the many hospital settings in which infected patients are treated, there have not been additional cases of transmission. This evidence strongly suggests that this fourth form of inoculation transmission is uncommon and preventable with adequate precautions.

## Perinatal Transmission

Perinatal transmission, apparently occurring during pregnancy or childbirth, is the most common cause of AIDS infection in infants and small children. These cases result from the mother's HIV infection, often stemming from her intravenous drug use. Seventy-seven percent of the pediatric AIDS cases reported to the CDC are from perinatal events. In these cases, the virus is passed to the unborn child in utero, during childbirth, or through breast milk. The mechanism of perinatal transmission has not completely been identified, and the timing has not been pinpointed. But there appears to be a 40-50 percent chance that an HIV-infected mother will give birth to a child who will be HIV antibody-positive at birth.[22] There has only been one known case of confirmed transmission of the virus through breast milk.[23] In this case, the mother was infected by a blood transfusion after delivery, and the child became infected through nursing. About a third of children who test HIV antibody-positive at birth will also test negative months later; this happens because infants shed their mothers' antibodies and form their own. Thus an infant may have tested positive because it retained some of its mother's *antibodies*, but was not itself harboring the virus. When its own immune system begins to mature, and the mother's antibodies naturally degrade and disappear, the infant will no longer test positive. Infants may change from positive to negative status as long as 15 months after birth; it is crucial therefore that they be re-tested until then, according to some clinicians.[24]

The majority of pediatric cases have come from New York City, New Jersey, and Florida—areas with high concentrations of IV drug users. Perinatal transmission cases also come disproportionately from minority populations, as these populations are overrepresented among IV drug users. Eighty-five percent of the total cases of perinatal transmission occurred among blacks or Hispanics, a figure which represents 65 percent of all pediatric AIDS cases.[25]

## Transmission through Sexual Contact

The AIDS virus can be transmitted through either homosexual or heterosexual contact. Activities that may produce small breaks in mucosa, such as anal intercourse, appear to be the most risky. However, vaginal intercourse is also a mode of male-to-female or female-to-male transmission.

Unprotected homosexual activity remains the single largest risk behavior for transmission of the AIDS virus. Homosexual or bisexual males constitute 64 percent of the total number of AIDS cases reported. Having receptive anal intercourse as well as having many partners are both linked to increased chances of contracting infection.[26] Both factors increase the likelihood of contact with another infected male and the likelihood of producing small fissures in the anal mucosa.

The extent of heterosexual transmission has been widely discussed. While the proportion of total cases stemming from heterosexual transmission has remained constant at 4 percent, the *number* of heterosexual cases has increased more rapidly than the numbers in other categories. For example, in September 1984, only 25 cases of heterosexual transmission to women were reported to the New York City Health Department; just two years later that figure had multiplied more than five times. The number of AIDS cases among female IV drug users also increased dramatically during this time, to three and a half times the 1984 figure.[27] These data do not necessarily predict an explosion of AIDS into the non-IV drug-using population, but they do suggest increasing numbers of cases among those in regular sexual contact with IV users and/or bisexual men.

The question of the efficiency of heterosexual transmission is an important one. Most of the data on heterosexual transmission comes from studies of the sexual partners of intravenous drug users, prostitutes, or other persons with AIDS and from American military samples.

Small studies of the sexual partners of persons with AIDS indicate that regular unprotected sexual activity results in a high rate of infection in the partners. In a U.S. study of 24 seronegative partners of persons with AIDS, of the 10 pairs who used condoms over the 12-36 month study period, only one partner became infected. By comparison, of the 14 pairs who engaged in unprotected sexual activity, 12 partners (88%) became infected.[28] Padian reports that the risk of heterosexual transmission from vaginal intercourse increases with frequency of contact, but seems to remain stable after a threshold of 10-20 exposures.[29] This is not true for anal intercourse in her sample. In this small sample, 88 percent of partners of persons with AIDS became infected, and 30 percent of persons who were seropositive but asymptomatic got the disease. Similar findings have been reported among sexual partners of IV drug users in New York. Since 60 to 75 percent of IV users are male, and approximately 95 percent are heterosexual, the number of non-IV drug-using sexual partners for this population is significant.[30] One study in particular found that nearly half the female partners of male IV users did not themselves use IV drugs.[31]

Studies of American military recruits report that nationally, the ratio of male-to-female seropositivity is 2.7 to 1, but almost one-to-one in areas of highest population prevalence of seropositivity.[32] Among this group were numerous married couples in which both parties were HIV antibody-positive. The areas where male-to-female ratios are almost equal are areas in which substantial portions of the cases involve IV drug use—highlighting again the strong link between heterosexual transmission and intravenous drug use. The largest subgroup of heterosexual transmission cases involves partners of IV users from the New York metropolitan area and South Florida. To date there is little evidence of major transmission in the "second wave"; for example, infection from IV user to non-drug-using partner to another non-drug-using sexual partner.

For criminal justice agencies, the case of heterosexual transmission from prostitutes is a particularly important issue. In both European and U.S. studies of prostitutes, the percentage of seropositivity is high, due primarily to the large number of IV drug users in this group. In a New York study, for example, 42 percent of street prostitutes were IV drug users,[33] and in a New Jersey study, half of the IV drug-using prostitutes were seropositive.[34] There is some speculation that prostitutes may also be more susceptible to HIV infection, due to high rates of other sexually-transmitted diseases.[35] Prostitutes also come into contact with both IV drug users and persons who have multiple sexual partners. In the CDC multi-city study of prostitutes, 11 percent of the prostitutes who engaged in unprotected sex with customers tested positive for HIV, compared to *none* of the 22 who always used condoms for vaginal intercourse.[6]

Transmission from infected prostitutes appears to be surprisingly low, however. First, many prostitutes both here and abroad practice safer sex techniques in response to both AIDS and other sexually transmitted diseases.[37] In addition, the frequency of contact with an infected prostitute may be too low to produce effective transmission to any one customer. As a result, only a handful of reported cases involve transmission through heterosexual contact with a prostitute.

It is important to note that single-contact heterosexual transmission does occur, but it appears less likely than was first thought. Padian's results, the prostitution data, and the overall case distribution material all suggest that regular or repeated sexual contact with an infected individual is required for heterosexual transmission. It should be emphasized, however, that the possibility exists of single-contact transmission between heterosexuals.

## Common Misconceptions about Transmission

It is critical for education and training programs to address some of the common misconceptions about AIDS transmission. Here, we will briefly review some of the most common areas of confusion.

- ***Can I get infected from kissing, hugging, or sharing dishes, silverware, toothbrushes, razors, with a person with AIDS or who is seropositive?***

  There is strong evidence that HIV infection does not occur from sharing household items, even those intimate household items such as a toothbrush or razor. Seven separate studies totaling almost 500 family members of persons with AIDS in daily intimate contact show *no* cases of infection which did not come from one of the known risk factors.[38] In some cases, toothbrushes, razors, toilets, and such intimate household items were routinely shared with the infected party. In addition, family members and health care workers often kiss or hug AIDS patients, and no cases of infection through this route have been reported. CDC does recommend avoidance of deep kissing, however, due to the possibility of small breaks in skin or sores which may contact mucosa and, although highly unlikely, result in transmission. Similarly, though no cases exist, sharing razors and toothbrushes should be avoided as the possibility exists that small amounts of blood could be transferred.

- ***Can I contract HIV on the job? What if I have to administer emergency first aid to a co-worker?***

There is absolutely no evidence to support fears of transmission in the normal course of job performance. Again, in a study of persons with several years of close personal contact in a residential school setting with hemophiliac children who were seropositive, no non-hemophiliac children became infected.[39] There have been no cases of infection among law enforcement personnel, paramedics, or firemen as a result of giving mouth-to-mouth resuscitation to an infected person. Hammett also finds no cases of infection reported in correctional personnel through occupational contact in the three years of examination of AIDS in correctional settings.[40] As a general precaution, however, masks or resuscitation cups should be used in *all* cases of resuscitation to protect both parties from this and numerous other contagious infections.

- ***I have heard that the AIDS virus is in saliva. Can I get infected if an infected person bites me?***

HIV can be isolated in a number of body fluids—saliva, tears, urine—though the concentrations in these fluids is low and, in recent culture studies, very rarely viable.[41] It has been estimated, therefore, that it would take one quart of saliva or urine entering the bloodstream to produce infection.[42]

Biting or spitting generally involves small amounts of saliva which, as has been discussed, poses no real threat. Biting which breaks the skin may bring saliva of an infected person in contact with the blood of the person bitten. But only if the person biting has an open sore or wound in his or her mouth can blood mix with the blood of the person bitten. Thus, given both the low frequency of the usually one-time event, and the unlikelihood of enough infected blood being involved, it is not surprising that there have been no reported infections among persons who have been bitten by someone with AIDS.

- ***Is there risk of transmission to staff who conduct urine testing?***

Again, the concentration of the virus in HIV-infected urine is so small that transmission would require exposure to a much larger quantity of urine than is handled in routine testing. Moreover, good hygiene would indicate that staff should be wearing gloves to handle urine samples, to avoid any contact with the many other, far more readily transmitted infectious agents found in human urine.

- ***Should I allow an HIV positive probationer or parolee to work in a food-handling job?***

Much of the same evidence holds here. HIV antibody-positive individuals have undoubtedly been employed in food handling, and no cases of transmission have appeared as a result. Persons with AIDS have also prepared food as members of a family with no cases of infection resulting. Hypothetically, an individual could bleed or spit into food preparations, which could be eaten by someone with a cut or sore in the mouth. Even in this unlikely scenario, any virus would almost certainly be killed by the stomach acids. Therefore, CDC specifically recommends against screening food service workers for HIV.

- ***Since the AIDS virus is a blood-borne virus, can I get it from an insect that has bitten someone who is infected?***

Important evidence about insect transmission comes from areas where the virus is well-established, and prevalence of HIV infection is high. In studies of areas of Africa where large portions of the adult population are infected, and in Belle Glade, Florida, where there is an unusually high concentration of HIV infection, there is no evidence of infection outside the known risk groups—IV drug users, homosexuals and their partners.[43] If insects transmitted the infection, one would expect children, the elderly, and all segments of the population to be affected. In addition, the insect must be able to replicate the virus in its own system before it could transmit it to humans; it has been found that mosquitoes are unable to do this with the AIDS virus.

## Current Treatments and Vaccine Research

A great deal of scientific attention has been focused on the AIDS virus. To date, no cure for the underlying immune suppression caused by the virus has been found. There are, however, a few treatments currently available which appear to prolong life and make the AIDS patient more comfortable. There are also more than 100 studies of 40 or more substances under study by the Food and Drug Administration for use in the treatment of AIDS.[44]

Treatments center around two types of drugs. Anti-viral agents attack or inhibit the growth of the virus; immunomodulating agents work to boost or restore the immune system. As of this writing, only azidothymidine (AZT) is approved by the Food and Drug Administration specifically for treatment of AIDS or advanced ARC, although many more agents are under study. Other drugs, which are already approved for other uses, may be included in AIDS treatment; an example is pentamidine, used to treat *Pneumocystis carinii* pneumonia (PCP). AZT is an anti-viral drug that attacks the replication cycle of the virus and has had considerable success in extending the life of persons with AIDS. While still an expensive therapy, the price of AZT has been reduced from about $10,000 to $7,500 per patient per year. It is also a drug approved for use only in seriously immune-compromised persons, those with T-4 cell counts below 200. In a healthy individual, the T-4 cell count ranges from 700 to 1,400; in a person with ARC or AIDS, the count can range from 50 to 200.[45] AZT, therefore, could not be used to retard the virus among asymptomatic seropositive persons or those in the very early stages of illness.

Other drugs, like pentamine isethionate or Ampligen, are designed to stimulate the immune system (increase the number of T-4 cells), and inhibit the spread of the virus. Some treatments under study involve the combination of types of drugs. For example, researchers report encouraging results in the treatment of PCP using pentamidine, an anti-cancer drug which interferes with the metabolism of the organism causing PCP, and a vitamin-like substance, called Trimextrate, which protects normal cells from destruction.[46]

In all of these therapies, the illness is retarded or thwarted somewhat, rather than cured. To date, no therapy has provided a cure or complete remission. Therefore, a great deal of effort is being made in the search for a vaccine.

Scientists report that the AIDS virus presents a particularly difficult vaccine problem in that "it hides in cells, it mutates rapidly, and it survives despite many immune responses that would normally rid the body of an invading virus".[47] It appears, for example, that people infected with the live AIDS virus develop antibodies which, in the laboratory, inactivate the virus. These people, however, may still become sick and die, indicating that the kind of immune response which will protect a person from AIDS infection is unknown, and that vaccines, like those used in the development of the polio or measles immunizations, may not work. There are also no animal models appropriate for vaccine research. Chimps who can be infected successfully with the virus never develop the disease.

The goal of the vaccine research is to find a vaccine that will produce a strong group-specific antibody that could protect against the diverse AIDS virus strains. Estimates as to the timetable for vaccine availability reflect these problems, and range from several years to decades. There are currently several AIDS vaccines in clinical trials in humans. However, a recent article in *Science* concluded: "Scientists have known since they began to work on an AIDS vaccine that it would not be easy, but perhaps no one realized it would be so difficult".[48]

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# Chapter 2: EPIDEMIOLOGY OF AIDS

This chapter examines the epidemiology of AIDS, its incidence and prevalence. We first discuss the spread of the disease in the general population, and then we report on AIDS in parole and probation systems. For the general population we draw on data collected by the Centers for Disease Control, including numbers of cumulative and current cases of AIDS across the country. For the prevalence information for parole and probation populations, we rely on the data provided by 47 parole and 68 probation agencies. In addition, we will discuss briefly data from annual surveys of prisons and jails in the United States, conducted for the publication series AIDS in Correctional Facilities, a project also sponsored by the National Institute of Justice (NIJ).

## AIDS in the United States

Each year the numbers of AIDS cases grows at an alarming rate. Just four years ago, only 4,000 cases had been reported to the CDC. By May of 1988, almost 60,000 cases had been reported; of this figure, more than 10,000 had been reported since January 1 (Figure 2.1). Almost 1,000 of the total cases are in children under the age of 13. The comment heard often early in the epidemic that the early cases were only the "tip of the iceberg" has proven, tragically to be accurate. Of the cases diagnosed as of this report, 56 percent have died.

While AIDS has now been reported in all 50 states (Figure 2.2), the majority of cases are still concentrated in the Northeast and West. California, New York and Florida account for more than 50 percent of the cases; Texas and New Jersey add an additional 13 percent. Moreover, these five states together contribute 68 percent of the nation's total pediatric cases. However, as Figure 2.2 indicates, though case numbers are small in some states, they may represent early stages or new areas of the infections. For example, of the 19 cases reported to date in Idaho, 15 were diagnosed in the last two years.

Even within high-incidence states, cases are geographically concentrated in certain areas, areas with large numbers of intravenous drug users and an active homosexual population. Figure 2.3 shows those standard metropolitan areas which have the largest number of AIDS cases reported and the progression of case accumulation since 1985. The highest incidence area, New York City, has considerably more cases than any other city, though smaller cities such as Jersey City, New Jersey, contribute a disproportionate share of cases relative to their populations. This is due to the large intravenous drug user population of cities like Newark and Jersey City, suburbs to New York City and a short train ride to those areas of the Lower East Side of Manhattan where drugs are sold and used.

In addition to the number of confirmed AIDS cases which these figures represent, the National Academy of Sciences estimates that there may be as many as 50,000-125,000 cases of AIDS-Related Complex (ARC) in the U.S. and as many as 1.5 million persons who are seropositive but currently asymptomatic.[1] It is estimated that by 1991, 270,000 AIDS cases will have been diagnosed and more than 50,000 persons each year will die of AIDS.[2]

Most adult AIDS cases have been white (59%) and male (92%) and stem from transmission through homosexual activity (63%). (See Figure 2.1 and also 2.4, which shows the breakdown of AIDS cases by race/ethnic group and by transmission category.) However, minorities are overrepresented in comparison to their numbers in the general population, particularly in the intravenous drug use risk category. Of the IV drug use-related cases, 75 percent occur among blacks or Hispanics. These two groups make up less than 25 percent of the nation's population. The majority of female AIDS cases are also related to IV drug use. Of the 5,776 female AIDS cases diagnosed to date, 51 percent are IV drug users.

Figure 2.5 shows that 88 percent of AIDS cases have been diagnosed in persons 20-49 years old, with the majority of these occurring in the 30-40 age group. While relatively few cases (257) have been diagnosed in teenagers, it is important to interpret these data with caution. A brief look at the number of cases which appear in the 20-29 age category shows that *21 percent* of all cases fall in this group. Given the long incubation period of the virus, often spanning several years, it is likely that infection of a substantial portion of this group occurred in the teen years.

Heterosexually transmitted cases represent 4 percent of the total cases reported (Figure 2.4). Male-to-female transmission is more common, due in part to the larger ratio of male IV drug users to female IV users in the country and to the homosexual and bisexual contact source of male infection. Consequently, heterosexual

Figure 2.1

BREAKDOWN OF TOTAL AIDS CASES IN THE U.S.
BY TRANSMISSION CATEGORY AND SEX[1,2]

| | MALES | | | | FEMALES | | | | TOTAL | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Since Jan 1 | | Cumulative | | Since Jan 1 | | Cumulative | | Since Jan 1 | | Cumulative | |
| ADULTS/ADOLESCENTS | Number | (%) | Number | (%) | Number | (%) | Number | (%) | Number | (%) | Number | (%) |
| Homosexual/Bisexual Male | 5776 | (63) | 37999 | (69) | | | | | 5776 | (56) | 37999 | (63) |
| Intravenous (IV) Drug Abuser | 1908 | (21) | 8607 | (16) | 583 | (54) | 2438 | (51) | 2491 | (24) | 11045 | (18) |
| Homosexual Male and IV Drug Abuser | 672 | (7) | 4438 | (8) | | | | | 672 | (7) | 4438 | (7) |
| Hemophilia/Coagulation Disorder | 101 | (1) | 568 | (1) | 5 | (0) | 23 | (0) | 106 | (1) | 591 | (1) |
| Heterosexual Cases[3] | 180 | (2) | 1101 | (2) | 259 | (24) | 1362 | (29) | 439 | (4) | 2463 | (4) |
| Transfusion, Blood/Components | 191 | (2) | 951 | (2) | 115 | (11) | 516 | (11) | 306 | (3) | 1467 | (2) |
| Undetermined[4] | 403 | (4) | 1493 | (3) | 108 | (10) | 401 | (8) | 511 | (5) | 1894 | (3) |
| SUBTOTAL (% of all cases) | 9231 | (90) | 55157 | (92) | 1070 | (10) | 4740 | (8) | 10301 | (100) | 59897 | (100) |
| CHILDREN[5] | | | | | | | | | | | | |
| Hemophilia/Coagulation Disorder | 12 | (11) | 51 | (10) | | | 2 | (0) | 12 | (6) | 53 | (6) |
| Parent with/at risk of AIDS[6] | 77 | (69) | 369 | (71) | 74 | (85) | 366 | (84) | 151 | (76) | 735 | (77) |
| Transfusion, Blood/Components | 19 | (17) | 80 | (15) | 10 | (11) | 51 | (12) | 29 | (15) | 131 | (14) |
| Undetermined[4] | 4 | (4) | 19 | (4) | 3 | (3) | 17 | (4) | 7 | (4) | 36 | (4) |
| SUBTOTAL (% of all cases) | 112 | (56) | 519 | (54) | 87 | (44) | 436 | (46) | 199 | (100) | 955 | (100) |
| TOTAL (% of all cases) | 9343 | (89) | 55676 | (91) | 1157 | (11) | 5176 | (9) | 10500 | (100) | 60852[7] | (100) |

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[1] These data are provisional.

[2] Cases with more than one risk factor other than the combinations listed in the tables or footnotes are tabulated only in the category listed first.

[3] Includes 1460 persons (321 men, 1139 women) who have had heterosexual contact with a person with AIDS or at risk for AIDS and 1003 persons (780 men, 223 women) without other identified risks who were born in countries in which heterosexual transmission is believed to play a major role although precise means of transmission have not yet been fully defined.

[4] Includes patients on whom risk information is incomplete (due to death, refusal to be interviewed or loss to follow-up), patients still under investigation, men reported only to have had heterosexual contact with a prostitute, and interviewed patients for whom no specific risk was identified; also includes one health-care worker who seroconverted to HIV and developed AIDS after documented needlestick to blood.

[5] Includes all patients under 13 years of age at time of diagnosis.

[6] Epidemiologic data suggest transmission from an infected mother to her fetus or infant during the perinatal period.

[7] Includes 5901 patients who meet only the 1987 revised surveillance definition for AIDS.

Source: CDC, AIDS Weekly Surveillance Report - United States, May 2, 1988.

contact is more frequently a source of infection for women than for men. This is reflected in the fact that 29 percent of all female cases result from heterosexual contact, compared to only 2 percent of the total male cases reported (Figure 2.1).

## What Does This Have To Do With Probation and Parole?

First, the age group at greatest risk for AIDS, those 20-39 years old, is also the age group in which the greatest number of criminal offenders cluster. Sixty-one percent of all persons arrested in the United States are between 20-39 years old.[3] Second, the population of offenders has a high proportion of intravenous drug users. Recent data from the NIJ Drug Use Forecasting System indicates that between 5 and 25 percent of male arrestees report ever injecting heroin, while 7 to 27 percent report ever injecting cocaine. These statistics are based on voluntary self-reports and should therefore be interpreted as minimum estimates of injection in arrestees.[4] Consequently, because age and substance abuse are predictors, we might expect that large numbers of persons entering the criminal justice system are at high risk for HIV.

Not surprisingly, data from the 1987 edition of NIJ's AIDS in Correctional Facilities indicate that many persons paroled after incarceration may be HIV-infected and/or have AIDS.[5] In the facilities surveyed nationwide, 1964 cumulative cases of AIDS were reported; of this number there were 295 current cases in the Federal system and 126 in the city or county systems. These figures represent an increase of 156 percent in the three years since the first NIJ survey of prisons and

Figure 2.2

Breakdown of Total
. AIDS Cases in U.S. by State of Residence

| STATE OF RESIDENCE | Year Ending MAY 2, 1987 |  | Year Ending MAY 2, 1988 |  | CUMULATIVE TOTAL SINCE JUNE 1981 |  |  |  |  |  |
|---|---|---|---|---|---|---|---|---|---|---|
|  |  |  |  |  | Adult/Adolescent |  | Children |  | Total |  |
|  | Number | Percent | Number | Percent | Number | Percent | Number | Percent | Number | Percent |
| New York | 3934 | (25.8) | 5083 | (20.0) | 15429 | (25.8) | 300 | (31.4) | 15729 | (25.8) |
| California | 3327 | (21.8) | 5204 | (20.5) | 13035 | (21.8) | 71 | (7.4) | 13106 | (21.5) |
| Florida | 1148 | (7.5) | 1848 | (7.3) | 4232 | (7.1) | 113 | (11.8) | 4345 | (7.1) |
| Texas | 1146 | (7.5) | 1863 | (7.3) | 4081 | (6.8) | 38 | (4.0) | 4119 | (6.8) |
| New Jersey | 864 | (5.7) | 1933 | (7.6) | 3893 | (6.5) | 128 | (13.4) | 4021 | (6.6) |
| Illinois | 417 | (2.7) | 803 | (3.2) | 1655 | (2.8) | 22 | (2.3) | 1677 | (2.8) |
| Pennsylvania | 381 | (2.5) | 764 | (3.0) | 1556 | (2.6) | 22 | (2.3) | 1578 | (2.6) |
| Georgia | 362 | (2.4) | 544 | (2.1) | 1250 | (2.1) | 20 | (2.1) | 1270 | (2.1) |
| Massachusetts | 315 | (2.1) | 528 | (2.1) | 1219 | (2.0) | 22 | (2.3) | 1241 | (2.0) |
| District of Columbia | 275 | (1.8) | 510 | (2.0) | 1140 | (1.9) | 12 | (1.3) | 1152 | (1.9) |
| Maryland | 280 | (1.8) | 463 | (1.8) | 1014 | (1.7) | 21 | (2.2) | 1035 | (1.7) |
| Puerto Rico | 95 | (0.6) | 577 | (2.3) | 873 | (1.5) | 31 | (3.2) | 904 | (1.5) |
| Louisiana | 195 | (1.3) | 385 | (1.5) | 796 | (1.3) | 11 | (1.2) | 807 | (1.3) |
| Washington | 208 | (1.4) | 381 | (1.5) | 798 | (1.3) | 4 | (0.4) | 802 | (1.3) |
| Ohio | 251 | (1.6) | 389 | (1.5) | 751 | (1.3) | 12 | (1.3) | 763 | (1.3) |
| Connecticut | 179 | (1.2) | 313 | (1.2) | 696 | (1.2) | 24 | (2.5) | 720 | (1.2) |
| Virginia | 169 | (1.1) | 297 | (1.2) | 687 | (1.1) | 14 | (1.5) | 701 | (1.2) |
| Colorado | 178 | (1.2) | 274 | (1.1) | 638 | (1.1) | 4 | (0.4) | 642 | (1.1) |
| Michigan | 173 | (1.1) | 271 | (1.1) | 588 | (1.0) | 10 | (1.0) | 598 | (1.0) |
| Missouri | 126 | (0.8) | 303 | (1.2) | 527 | (0.9) | 7 | (0.7) | 534 | (0.9) |
| Arizona | 79 | (0.5) | 315 | (1.2) | 492 | (0.8) | 3 | (0.3) | 495 | (0.8) |
| North Carolina | 90 | (0.6) | 270 | (1.1) | 469 | (0.8) | 9 | (0.9) | 478 | (0.8) |
| Oregon | 80 | (0.5) | 193 | (0.8) | 349 | (0.6) | 1 | (0.1) | 350 | (0.6) |
| Minnesota | 98 | (0.6) | 134 | (0.5) | 327 | (0.5) | 2 | (0.2) | 329 | (0.5) |
| Indiana | 78 | (0.5) | 151 | (0.6) | 308 | (0.5) | 3 | (0.3) | 311 | (0.5) |
| Tennessee | 59 | (0.4) | 196 | (0.8) | 294 | (0.5) | 5 | (0.5) | 299 | (0.5) |
| Alabama | 65 | (0.4) | 179 | (0.7) | 285 | (0.5) | 8 | (0.8) | 293 | (0.5) |
| South Carolina | 65 | (0.4) | 111 | (0.4) | 242 | (0.4) | 5 | (0.5) | 247 | (0.4) |
| Oklahoma | 56 | (0.4) | 119 | (0.5) | 218 | (0.4) | 6 | (0.6) | 224 | (0.4) |
| Hawaii | 69 | (0.5) | 96 | (0.4) | 221 | (0.4) | 1 | (0.1) | 222 | (0.4) |
| Wisconsin | 63 | (0.4) | 95 | (0.4) | 206 | (0.3) | 1 | (0.1) | 207 | (0.3) |
| Nevada | 52 | (0.3) | 115 | (0.5) | 201 | (0.3) | 2 | (0.2) | 203 | (0.3) |
| Kentucky | 36 | (0.2) | 65 | (0.3) | 145 | (0.2) |  |  | 145 | (0.2) |
| Kansas | 40 | (0.3) | 72 | (0.3) | 139 | (0.2) | 2 | (0.2) | 141 | (0.2) |
| Rhode Island | 45 | (0.3) | 62 | (0.2) | 131 | (0.2) | 3 | (0.3) | 134 | (0.2) |
| Mississippi | 33 | (0.2) | 79 | (0.3) | 128 | (0.2) |  |  | 128 | (0.2) |
| Arkansas | 34 | (0.2) | 63 | (0.2) | 119 | (0.2) |  |  | 119 | (0.2) |
| Utah | 25 | (0.2) | 57 | (0.2) | 114 | (0.2) | 3 | (0.3) | 117 | (0.2) |
| New Mexico | 32 | (0.2) | 48 | (0.2) | 103 | (0.2) | 1 | (0.1) | 104 | (0.2) |
| Delaware | 24 | (0.2) | 42 | (0.2) | 90 | (0.2) | 2 | (0.2) | 92 | (0.2) |
| Iowa | 17 | (0.1) | 33 | (0.1) | 72 | (0.1) | 2 | (0.2) | 74 | (0.1) |
| Maine | 24 | (0.2) | 30 | (0.1) | 71 | (0.1) | 2 | (0.2) | 73 | (0.1) |
| New Hampshire | 15 | (0.1) | 36 | (0.1) | 61 | (0.1) | 3 | (0.3) | 64 | (0.1) |
| Nebraska | 15 | (0.1) | 34 | (0.1) | 62 | (0.1) |  |  | 62 | (0.1) |
| West Virginia | 14 | (0.1) | 17 | (0.1) | 44 | (0.1) | 2 | (0.2) | 46 | (0.1) |
| Alaska | 10 | (0.1) | 15 | (0.1) | 42 | (0.1) |  |  | 42 | (0.1) |
| Vermont | 8 | (0.1) | 14 | (0.1) | 28 | (0.0) |  |  | 28 | (0.0) |
| Idaho | 5 | (0.0) | 10 | (0.0) | 17 | (0.0) | 2 | (0.2) | 19 | (0.0) |
| Montana | 4 | (0.0) | 10 | (0.0) | 18 | (0.0) |  |  | 18 | (0.0) |
| Virgin Islands | 3 | (0.0) | 9 | (0.0) | 15 | (0.0) | 1 | (0.1) | 16 | (0.0) |
| Wyoming | 4 | (0.0) | 2 | (0.0) | 9 | (0.0) |  |  | 9 | (0.0) |
| South Dakota | 2 | (0.0) | 4 | (0.0) | 8 | (0.0) |  |  | 8 | (0.0) |
| North Dakota | 2 | (0.0) |  |  | 6 | (0.0) |  |  | 6 | (0.0) |
| Guam |  |  | 3 | (0.0) | 4 | (0.0) |  |  | 4 | (0.0) |
| Trust Territory |  |  |  |  | 1 | (0.0) |  |  | 1 | (0.0) |
| TOTAL | 15269 | (100.0) | 25412 | (100.0) | 59897 | (100.0) | 955 | (100.0) | 60852 | (100.0) |

Figure 2.3

BREAKDOWN OF AIDS CASES IN THE U.S.
BY STANDARD METROPOLITAN STATISTICAL AREA (SMSA) OF RESIDENCE

| SMSA OF RESIDENCE | POPULATION[1] | BEFORE 1985 | 1985 | 1986 | 1987 | 1988[2] | CUMULATIVE TOTAL |
|---|---|---|---|---|---|---|---|
| New York, NY | 9.12 | 3296 | 2619 | 3541 | 3921 | 815 | 14192 |
| San Francisco, CA | 3.25 | 1090 | 967 | 1414 | 1524 | 358 | 5353 |
| Los Angeles, CA | 7.48 | 808 | 880 | 1347 | 1538 | 194 | 4767 |
| Houston, TX | 2.91 | 293 | 340 | 618 | 690 | 72 | 2013 |
| Washington, DC | 3.06 | 221 | 341 | 452 | 672 | 149 | 1835 |
| Newark, NJ | 1.97 | 268 | 267 | 411 | 680 | 100 | 1726 |
| Miami, FL | 1.63 | 377 | 293 | 410 | 428 | 44 | 1552 |
| Chicago, IL | 7.10 | 199 | 234 | 399 | 581 | 100 | 1513 |
| Dallas, TX | 2.97 | 117 | 178 | 336 | 550 | 59 | 1240 |
| Philadelphia, PA | 4.72 | 174 | 208 | 333 | 459 | 55 | 1229 |
| Atlanta, GA | 2.03 | 112 | 168 | 271 | 334 | 52 | 937 |
| Boston, MA | 2.76 | 136 | 151 | 216 | 328 | 52 | 883 |
| San Diego, CA | 1.86 | 78 | 118 | 215 | 315 | 68 | 794 |
| Ft. Lauderdale, FL | 1.02 | 97 | 131 | 209 | 289 | 58 | 784 |
| Jersey City, NJ | 0.56 | 114 | 144 | 206 | 244 | 25 | 733 |
| Nassau-Suffolk, NY | 2.61 | 123 | 121 | 205 | 201 | 29 | 679 |
| Seattle, WA | 1.61 | 66 | 94 | 179 | 234 | 37 | 610 |
| New Orleans, LA | 1.19 | 70 | 97 | 151 | 215 | 22 | 555 |
| Denver, CO | 1.62 | 63 | 85 | 139 | 201 | 55 | 543 |
| Baltimore, MD | 2.17 | 59 | 81 | 139 | 218 | 39 | 536 |
| REST OF U.S. | 168.48 | 2213 | 2865 | 4845 | 7218 | 1237 | 18378 |
| TOTAL | 230.11 | 9974 | 10382 | 16036 | 20840 | 3620 | 60852 |

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[1] Population of SMSA's in millions as reported in the 1980 census.

[2] Cases diagnosed in this calendar year and reported to CDC as of date of this summary.

Source: CDC, AIDS Weekly Surveillance Report - United States, May 2, 1988.

jails was conducted in 1985, and a 59 percent increase since last year. However, the rate of increase in the general population is even greater—61 percent in the past year. Unlike cases in the general population, however, *all* of the AIDS cases in persons incarcerated must be dealt with by community supervision agencies upon release, and increases in these numbers represent escalating problems for these agencies.

## AIDS in Community Supervision Populations

Figure 2.6 represents the numbers of confirmed AIDS cases reported nationally in parole and probation agencies. There were a total of 161 cases in parole and 171 cases in probation reported. These figures represent a very conservative estimate of the number of cases in community supervision, however. Many of the agencies (28 parole and 46 probation) reported that they could give no numerical estimate, but it should *not* be assumed that this inability indicates that there were no cases in populations served by these agencies. These respondents reported that it was impossible to respond either because their areas have no mechanism for reporting cases to a central organization; or that confidentiality policies in their states require that they not report cases. Thus, the only true "no case" instances are those reported as "zero."

As might be predicted from the general population data, a few areas contribute the bulk of reported cases in community supervision. In the case of parole, one state with 125 cases represents 78 percent of all cases reported nationwide. In the case of probation, six probation systems contributed 68 percent of the total cases reported. Figure 2.7 shows the distribution of cases nationwide, for those states which reported them in the survey.

So few agencies were able to provide any information about cases of ARC in their jurisdictions that we are unable to report even an estimate of its prevalence. Agencies were also unable to provide data about the

Figure 2.4

BREAKDOWN OF AIDS IN THE U.S.
BY RACE/ETHNIC GROUP AND BY TRANSMISSION CATEGORY

| | WHITE, NOT HISPANIC | | BLACK, NOT HISPANIC | | HISPANIC | | OTHER[1]/ UNKOWN | | TOTAL | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Cumulative | | Cumulative | | Cumulative | | Cumulative | | Cumulative | |
| ADULTS/ADOLESCENTS | Number | (%) | Number | (%) | Number | (%) | Number | (%) | Number | (%) |
| Homosexual/Bisexual Male | 27996 | (79) | 5842 | (38) | 3788 | (45) | 373 | (68) | 37999 | (63) |
| Intravenous (IV) Drug Abuser | 2134 | (6) | 5626 | (37) | 3228 | (38) | 57 | (10) | 11045 | (18) |
| Homosexual Male and IV Drug Abuser | 2735 | (8) | 1078 | (7) | 604 | (7) | 21 | (4) | 4438 | (7) |
| Hemophilia/Coagulation Disorder | 501 | (1) | 38 | (0) | 40 | (0) | 12 | (2) | 591 | (1) |
| Heterosexual Cases[2] | 435 | (1) | 1683 | (11) | 335 | (4) | 10 | (2) | 2463 | (4) |
| Transfusion, Blood Components | 1092 | (3) | 226 | (1) | 113 | (1) | 36 | (7) | 1467 | (2) |
| Undetermined[3] | 701 | (2) | 764 | (5) | 391 | (5) | 38 | (7) | 1894 | (3) |
| SUBTOTAL [% of all cases] | 35594 | [59] | 15257 | [25] | 8499 | [14] | 547 | [1] | 59897 | [100] |
| CHILDREN[4] | | | | | | | | | | |
| Hemophilia/Coagulation Disorder | 40 | (18) | 6 | (1) | 5 | (2) | 2 | (20) | 53 | (6) |
| Patient with/at risk of AIDS[5] | 104 | (47) | 454 | (88) | 170 | (81) | 7 | (70) | 735 | (77) |
| Transfusion, Blood/Components | 72 | (32) | 31 | (6) | 27 | (13) | 1 | (10) | 131 | (14) |
| Undetermined[3] | 7 | (3) | 22 | (4) | 7 | (3) | | | 36 | (4) |
| SUBTOTAL [% of all cases] | 223 | [23] | 513 | [54] | 209 | [22] | 10 | [1] | 955 | [100] |
| TOTAL [% of all cases] | 35817 | [59] | 15770 | [26] | 8708 | [14] | 557 | [1] | 60852[6] | [100] |

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[1] Includes patients whose race/ethnicity is Asian/Pacific Islander (353 persons) and American Indian/Alaskan Native (62 persons).

[2] Includes 1460 persons (321 men, 1139 women) who have had heterosexual contact with a person with AIDS or at risk for AIDS and 1003 persons (780 men, 223 women) without other identified risks who were born in countries in which heterosexual transmission is believed to play a major role although precise means of transmission have not yet been fully defined.

[3] Includes patients on whom risk information is incomplete (due to death, refusal to be interviewed or loss to follow-up), patients still under investigation, men reported only to have had heterosexual contact with a prostitute, and interviewed patients for whom no specific risk was identified; also includes one health-care worker who seroconverted to HIV and developed AIDS after documented needlestick to blood.

[4] Includes all patients under 13 years of age at time of diagnosis.

[5] Epidemiologic data suggest transmission from an infected mother to her fetus or infant during the perinatal period.

[6] Includes 5901 patients who meet only the 1987 revised surveillance definition for AIDS.

Source: CDC, AIDS Weekly Surveillance Report - United States, May 2, 1988.

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Figure 2.5

BREAKDOWN OF TOTAL AIDS CASES IN THE U.S.
BY AGE AT DIAGNOSIS AND BY RACIAL/ETHNIC GROUP

| | WHITE, NOT HISPANIC | | BLACK, NOT HISPANIC | | HISPANIC | | OTHER[8]/ UNKOWN | | TOTAL | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Cumulative | | Cumulative | | Cumulative | | Cumulative | | Cumulative | |
| **AGE GROUP** | Number | (%) | Number | (%) | Number | (%) | Number | (%) | Number | (%) |
| Under 5 | 151 | (0) | 460 | (3) | 185 | (2) | 8 | (1) | 804 | (1) |
| 5 - 12 | 72 | (0) | 53 | (0) | 24 | (0) | 2 | (0) | 151 | (0) |
| 13 - 19 | 120 | (0) | 88 | (1) | 44 | (1) | 5 | (1) | 257 | (0) |
| 20 - 29 | 6772 | (19) | 3670 | (23) | 2018 | (23) | 100 | (18) | 12560 | (21) |
| 30 - 39 | 16294 | (45) | 7607 | (48) | 4093 | (47) | 237 | (43) | 28231 | (46) |
| 40 - 49 | 8100 | (23) | 2725 | (17) | 1687 | (19) | 138 | (25) | 12650 | (21) |
| Over 49 | 4308 | (12) | 1167 | (7) | 657 | (8) | 67 | (12) | 6199 | (10) |
| TOTAL [% OF ALL CASES] | 35817 | [59] | 15770 | [26] | 8708 | [14] | 557 | [1] | 60852 | [100] |

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[8] Includes patients whose race/ethnicity is Asian/Pacific Islander (353 persons) and American Indian/Alaskan Native (62 persons).

Figure 2.6

## DISTRIBUTION OF CONFIRMED AIDS CASES AMONG PROBATIONERS AND PAROLEES, BY TYPE OF AGENCY, U.S.

PAROLE

| Number of AIDS Cases | n Systems | % Systems | n Cases | % Cases |
|---|---|---|---|---|
| 0 | 13 | 25% | 0 | 0% |
| 1 | 2 | 4 | 2 | 1 |
| 2 | 2 | 4 | 4 | 2 |
| 4 | 2 | 4 | 8 | 5 |
| 5 | 1 | 2 | 5 | 3 |
| 7 | 1 | 2 | 7 | 4 |
| 10 | 1 | 2 | 10 | 6 |
| 125 | 1 | 2 | 125 | 78 |
| No Estimate | 28 | 55 | -- | -- |
| TOTAL | 51 | 100% | 161 | 99%[a] |

N = 55
4 = missing

PROBATION

| Number of AIDS Cases | n Systems | % Systems | n Cases | % Cases |
|---|---|---|---|---|
| 0 | 11 | 14% | 0 | 0% |
| 1 | 3 | 4 | 3 | 2 |
| 2 | 6 | 8 | 12 | 7 |
| 3 | 3 | 4 | 9 | 5 |
| 5 | 1 | 1 | 5 | 3 |
| 6 | 2 | 3 | 12 | 7 |
| 7 | 2 | 3 | 14 | 8 |
| 15 | 4 | 5 | 60 | 35 |
| 20 | 1 | 1 | 20 | 12 |
| 36 | 1 | 1 | 36 | 21 |
| No Estimate | 46 | 58 | -- | --- |
| TOTAL | 80 | 102%[a] | 171 | 100% |

N = 80
0 = missing

__Source__: NIJ Survey of AIDS Issues for Probation and Parole

[a] Due to rounding

Figure 2.7

**BREAKDOWN OF TOTAL AIDS CASES IN COMMUNITY CORRECTIONS BY REGION AND TYPE OF AGENCY**

(Federal Probation and Parole Excluded)

| | NUMBER OF CASES | NUMBER OF STATES REPORTING CASES | PERCENTAGE OF TOTAL CASES |
|---|---|---|---|
| PROBATION | | | |
| New England[a] | 6 | 1 | 4% |
| Mid-Atlantic[b] | 26 | 2 | 15 |
| E.N. Central[c] | 39 | 2 | 23 |
| W.N. Central[d] | 0 | 0 | 0 |
| S. Atlantic[e] | 16 | 2 | 9 |
| E.S. Central[f] | 0 | 0 | 0 |
| W.S. Central[g] | 29 | 1 | 17 |
| Mountain[h] | 8 | 2 | 5 |
| Pacific[i] | 47 | 3 | 28 |
| TOTAL | 171 | 13* | 101%[j] |
| PAROLE | | | |
| New England[a] | 0 | 0 | 0 |
| Mid-Atlantic[b] | 125 | 1 | 78 |
| E.N. Central[c] | 5 | 1 | 3 |
| W.N. Central[d] | 4 | 1 | 3 |
| S. Atlantic[e] | 17 | 4 | 11 |
| E.S. Central[f] | 0 | 0 | 0 |
| W.S. Central[g] | 0 | 0 | 0 |
| Mountain[h] | 9 | 2 | 6 |
| Pacific[i] | 1 | 1 | ** |
| TOTAL | 161 | 10* | 101%[j] |

[a] Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut

[b] New York, New Jersey, Pennsylvania

[c] Ohio, Indiana, Illinois, Michigan, Wisconsin

[d] Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska, Kansas

[e] Delaware, Maryland, District of Columbia, Virginia, West Virginia, North Carolina, South Carolina, Georgia, Florida

[f] Kentucky, Tennessee, Alabama, Mississippi

[g] Arkansas, Louisiana, Oklahoma, Texas

[h] Montana, Idaho, Wyoming, Colorado, New Mexico, Arizona, Utah, Nevada

[i] Washington, Oregon, California, Alaska, Hawaii

[j] Due to rounding

*These figures represent the number of states reporting cases. _47_ states provided data for parole and _48_ states provided data for probation.

**Less than 1 percent.

_Source:_ NIJ Survey of AIDS Issues for Probation and Parole age, sex, ethnicity or mode of transmission of the AIDS cases reported.

## Sources of Infection and Seroprevalence

In interviews with community supervision personnel, administrators overwhelmingly cite intravenous drug use as the major source of transmission of AIDS among their populations. This is consistent with the reports of transmission in the 1987 prison and jail survey in which correctional systems attributed two-thirds of their total cases and 92 percent of female cases to IV drug abuse.[6] In areas of high incidence of IV drug abuse, the number of correctional AIDS cases attributable to IV drug use is much higher than the number of AIDS cases in the general population attributable to drug use. In New York State, for example, 96 percent of the correctional system AIDS cases are among IV drug users, while only 34 percent of the AIDS cases in the general New York State population are IV drug users.[7]

Since no jurisdictions currently conduct mass screening of all parolees or probationers, estimates of the seroprevalence rates in these populations are not available. However, the 1987 edition of NIJ's AIDS in Correctional Facilities estimates that, based on small or focused screening projects conducted in some states, from 0 to 2.6 percent of the prison and jail populations are seropositive.[8] Tests of high-risk populations such as IV drug users or homosexuals show predictably higher rates of seroprevalence. However, because of the variety of results, the difference in test groups, and the small samples, it is difficult to predict the actual figures for seroprevalence in the correctional population.

It has also been suggested that there may be increased numbers of AIDS cases in parole and probation due to high rates of transmission during incarceration. However, Hammett reports that currently available data suggest low rates of transmission within correctional facilities.[9] In 1985, Maryland conducted voluntary testing of a group of inmates who had been continuously incarcerated for seven or more years. The testing indicated a very low rate of infection (1.5%) in this group. It was assumed that any infection at all was attributable to transmission in prison because they had been continuously incarcerated since before the virus appeared in force in the United States Data from the New York and Florida correctional systems also suggest that infection while in prison is relatively rare. New York reports only five infected inmates (2.3%) among those who had been continuously confined for seven years, and Florida reports only 2 percent of such inmates infected.

In summary, the prevalence of AIDS in the community supervision population mirrors in many respects the prevalence and distribution of cases in the population in general. Cases are clustered in areas of the country where there are large numbers of intravenous drug users, active homosexual populations, and where the virus has been established in those populations for a number of years. A definitive number of cases in community corrections is not available due primarily to the lack of a reporting system for corrections personnel. Most of the cases reported are felt to be related to IV drug use.

It is important to note that practitioners as well as researchers are frustrated by the lack of information about the number of AIDS cases under community supervision. Many of the state parole and probation agencies reported that they would like to have summary data on the number of cases for purposes of planning, management and policy development, but were unable to collect such data without central support and administration. They find themselves relying on anecdotal information about the prevalence in their populations and/or estimating from the general information provided by the CDC on AIDS cases in their areas.

## NOTES

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   Institute of Medicine, *op. cit.*: 69-70.
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5. T.M. Hammett, *AIDS in Correctional Facilities: Issues and Options, Third Edition*, (Washington, D.C.: National Institute of Justice, U.S. Department of Justice, 1988).
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# Chapter 3: HIV ANTIBODY TESTING

In this chapter we will discuss the increasingly important and controversial question of testing persons for the presence of HIV antibodies. The debate about testing must include such crucial elements as cost, reliability of results, and the possibility of maintaining confidentiality.

In order to help administrators weigh these factors for decision making, we present information on the following:

- the tests in current use, their reliability and validity
- the current use of testing in parole and probation services
- policy recommendations for HIV testing in parole and probation

## The HIV Antibody Tests Currently in Use

There are two types of tests available for determining HIV infection: viral culture tests and serological tests. Viral culture tests involve growing the virus from samples; unfortunately, even highly skilled technicians in favorable conditions cannot grow HIV from blood in 40 percent or more of samples known to be infected. This is thought to be due primarily to differing levels of infection activity in samples.[1]

Serological tests, by contrast, measure antibodies to a viral agent present in the bloodstream. There are currently four serological tests available for identifying HIV infection: the enzyme-linked immunosorbant assay test (ELISA), the Western Blot immunopheresis test, the radioimmunoprecipitation test (RIP) and the cytoplasmic membrane immunofluorescence assay (IFA) test. The ELISA is the most commonly used test for HIV antibody screening because of its low cost, standardized procedures, reliability, and rapid turnaround of results.[2]

The most common sequence for HIV antibody testing begins with an ELISA test. If the result is positive, a second ELISA will be done for verification, and then the more labor-intensive Western Blot will serve as confirmation. Positive results on all three tests is considered laboratory evidence of HIV infection.

It is crucial to recognize that a positive result on this test series is not evidence that the subject has AIDS or will necessarily even develop AIDS. It merely shows the presence of antibodies to a core protein of the AIDS virus in the person's system. This means that at some time the individual was exposed to the virus and his or her system responded by producing antibodies. Persons testing positive may progress to ARC or AIDS or may remain asymptomatic. As we discussed in Chapter 1, infection with the virus is a necessary but not a sufficient condition to predict the appearance of the full illness.

It is not known what proportion of those who test positive will eventually manifest the disease; estimates range from 20 to 100 percent. As groups of HIV-infected individuals are studied over time, larger proportions are seen to develop AIDS; data suggest the great majority of those infected will manifest the disease. One San Francisco study of infected men showed that almost no AIDS cases appeared in the first two years after infection was discovered. But after eight and a half years, more than 40 percent had developed AIDS and a similar proportion had developed some symptoms of infection.[3] Another study of 288 seropositive men found that 22 percent had developed AIDS after three years of observation.[4]

Moreover, other data seem to show that the rate of progression from HIV infection to full AIDS increases with age; the only exception to this pattern are newborns, who have the highest progression rate of all.[5]

It is assumed that persons testing positive on the whole test series are infected with HIV and are therefore able to transmit the virus, even if they are not ill themselves.

The ELISA test was developed in the mid-1980s for the screening of the nation's blood supplies. The presence of HIV antibodies is signalled by a color reaction quantified through the use of a spectrophotometer. The higher the antibody level, the greater the optical density or color change. Therefore, there is no single "all or nothing" decision point, and testers must assign determination points at which infection is indicated. Manufacturers of the test kit provide suggested density points, based on the color change occurring for definitively-known positive or negative samples (for example, in the test results of persons with full-blown AIDS). However, different ELISA kits can provide varying results, even when testers follow the same standard manufacturer-suggested procedures. The

Figure 3.1

**HYPOTHETICAL HIV ANTIBODY SCREENING IN A POPULATION OF 500 WITH A 20% TRUE PREVALENCE OF INFECTION**

| | | True Infection Status | | Antibody Test Results | | False Results as % of True Group |
|---|---|---|---|---|---|---|
| | | n | % | Negative Result | Positive Result | |
| True Groups | Infected | 100 | 20% | 1 | 99 | 1%[a] |
| | Uninfected | 400 | 80% | 396 | 4 | 1%[b] |
| | Total | 500 | 100% | 397 | 103 | |
| | False Results as % of all Test Results in Category | | | 0.3%[c] | 3.9[d] | |

---

[a] This reflects the test sensitivity of 99%.

[b] This reflects the test specificity of 99%.

[c] This is the percentage of all negative results which would be false.

[d] This is the percentage of all positive results which would be false.

varying results, it has been suggested, may be attributable to variations in the batches of antigen used.

The Western Blot test, as we have noted, is used for confirmation after two positive ELISA results. For this test, inactivated virus is separated into component parts and "blotted" onto special paper. Complexes of viral protein and antibodies are seen as spots or bands in the final preparation.[6] The Western blot test is not sold commercially as a kit, nor does it have standardized interpretive procedures. Consequently, the interpretation criteria and reliability of results can vary widely with the laboratory and the skill of technicians. Federal efforts are currently underway to examine and standardize laboratory HIV antibody testing.

## Reliability and Validity

No medical test is 100 percent accurate. Tests vary in their accuracy, their reliability, and their consistency. Some mistakes are attributable to human errors, such as misreading or mislabeling, and others may be due to flaws in the test itself. But with a potential result as psychologically and emotionally devastating as HIV infection, it is critical to understand and try to minimize the errors associated with these tests.

One way to assess the validity of a test is to see how accurately it identifies those known to be infected. A "false negative" result occurs when a subject known to be infected tests negative. A "false positive," conversely, occurs when a test indicates someone is positive, or has antibodies to the disease, when he or she is not really infected.

All tests have some rate of error; these can be minimized by good definitions, standardized procedures, and careful administration. The CDC estimates that the sensitivity and specificity of the two-ELISA sequence is 99 percent. This means that on average, the test will correctly identify 99 out of every 100 persons who are actually infected (its sensitivity) and that it will correctly identify 99 out of 100 persons who are actually uninfected (its specificity).

However, this does *not* mean that only 1 percent of all the positive or negative results will be false. The percentage of false negative or positive results depends on the actual *prevalence* of infection in the population tested.

For example, Figure 3.1 shows that if the actual prevalence of infection in a test population of 500 people is 20 percent (meaning 100 people are actually infected), and the accuracy of the test is 99 percent, then 1 percent of the truly uninfected people, or 4 people, will receive a false positive result. In addition, 1 percent of the truly infected people, or 1 person, will

Figure 3.2

### HYPOTHETICAL HIV ANTIBODY SCREENING IN A POPULATION OF 500 WITH A 1% TRUE PREVALENCE OF INFECTION

| | | True Infection Status | | Antibody Test Results | | False Results as % of True Group |
|---|---|---|---|---|---|---|
| | | n | % | Negative Result | Positive Result | |
| True Groups | Infected | 5 | 1% | 0.05 | 4.95 | 1%[a] |
| | Uninfected | 495 | 99% | 490 | 5 | 1%[b] |
| | Total | 500 | 100% | 490.05 | 9.95 | |
| | False Results as % of all Test Results in Category | | | 0.01%[c] | 49.8%[d] | |

---

[a] This reflects the test sensitivity of 99%.

[b] This reflects the test specificity of 99%.

[c] This is the percentage of all negative results which would be false.

[d] This is the percentage of all positive results which would be false.

receive a false negative result. Thus 103 people in the group will test positively and four of them, or 3.9 percent of all positives, will be false.

The figures are quite different in the case of a population in which the true prevalence of infection is very low – for example, if our same 500 people have a prevalence rate of 1 percent (Figure 3.2). In this case, the percentage of positive results which are false rises dramatically. Four cases in this group will be truly infected and four cases will be false positives, making the error rate for false positives 50 percent for this low-incidence sample.

Another factor in the accuracy of HIV tests is the cutoff, or determination points, at which a blood sample is declared infected. Because the ELISA test was first developed to screen blood supplies, a process in which it was crucial to minimize false negative results (it being better to discard an actually uninfected unit than to transfuse someone with infected blood), the cutoff points were set quite low. But because the determination points were set conservatively, false positive results are automatically increased. This is appropriate for screening the blood supply, but it is a serious problem when false information is given to actually uninfected patients. And as we discussed, this is increasingly possible with low-incidence populations.

The manufacturers of ELISA test kits recommend setting the determination point differently for different runs of the test, taking into account the type of population. The cutoff point should be higher for low-incidence populations (to minimize false positives) and lower for high-incidence populations (to minimize false negatives). Unfortunately, the sophistication of test use varies widely; these adjustments are not always made.

In addition, the Western Blot test is not standardized, is highly labor-intensive, and relies heavily on the interpretive ability of the laboratory technicians. This ability varies, making results even of this confirmatory test less than definitive. Even the loss of a fraction of a percentage of specificity due to interpretive differences or lack of quality control becomes critical in the production of false positives in populations where the true prevalence of the virus is low.

For the example shown in Figure 3.2, adding even one-half of one percentage point of error to the results – making it only 98.5 percent accurate – due perhaps to laboratory reading error, would make the percentage of positive results that were false *75 percent.*

In reviewing the information on testing reliability and validity, it is important to remember the purpose of the test. Screening of low-risk populations, such as applicants for a marriage license, should have quite different interpretive criteria than tests used in clinics treating sexually transmitted diseases or IV drug use, or as part of the clinical diagnosis of persons with symptoms of AIDS.

To summarize, a single ELISA test or even two ELISA tests is not adequate for screening HIV, due primarily to variations in test application and an unacceptably high rate of false positives. Even the Western Blot confirmatory test, designed to identify and eliminate false positives, is subject to human error in handling materials and, most important, in interpretation of results.

It should also be pointed out that in order to be effective with high-risk populations, the test sequence must be repeated periodically. CDC estimates that the average time from infection to conversion (appearing positive on a test) ranges from six weeks to as long as 14 months.[7] Therefore, a person who does not test positive but has engaged in high-risk behavior during the previous six-month period is not necessarily free of infection and should be retested. Persons who continue to engage in high-risk behavior should also be tested periodically, as infection can occur at any time.

## NIJ Survey Results

During the time of the NIJ survey, December 1987 through March 1988, none of the state probation agencies reported mass screening; only the Texas Division of Parole reported that it was mass screening all new parolees at that time. In 1987, the Federal Bureau of Prisons instituted a program of testing all parole-eligible inmates within 60 days of release. In this program, approximately 2-3 percent test HIV antibody-positive.[8]

Six state parole or probation agencies currently conduct limited testing. One tests high-risk groups, two test persons with clinical indications of illness, three test in response to a specific incident, and three others test at the individual's request. Test information *is* available, however, to 40 percent of community corrections agencies, from a variety of sources. In one state, for example, results from any pre-trial testing which may have occurred are routinely available. Other sources of test results for parole officers include medical records (22%), court-ordered testing of high-risk groups (4%), and prior incarceration records (31%).

All agencies who test report the results to the probationer or parolee, and to his or her personal physician, as well as to the public health department. In only one state, the corrections agency is officially notified if a parolee tests positive. Only in one state is testing required of the parolee or probationer if he or she is involved in an incident in which HIV transmission may have occurred; other areas do not require testing in these cases but stated that they counsel or encourage the parolee, probationer, or officer involved to be tested. For those jurisdictions not requiring testing in such cases, the reasons may be related to state legal restrictions on requiring testing, the absence of a clear policy for such circumstances, or policy against such testing from the Department of Corrections.

Only in Georgia is HIV testing used in considering eligibility for parole. Beginning in 1988, the Georgia State Board of Pardons and Paroles began screening all inmates upon release. The Board may refuse to grant parole to seropositive inmates who fail to meet special supervisory conditions. These conditions are discussed in detail in Chapter 6. In Ohio, test results and/or illness may factor in the timing of parole and may influence early release decisions or decisions to delay release while appropriate treatment or care facilities are arranged.

The survey also asked agencies about their perceptions of the utility of testing. Of the agencies conducting testing, one reported that it found the test very useful, primarily to help target education and training programs for those identified. Three reported that the program has made no real difference. Two others said that it has had a negative effect on agency operations, mainly by adding the burden of maintaining confidentiality to management's responsibilities.

The agencies which do not test are divided in their perceptions of the utility of testing. Half of the jurisdictions feel that testing would be useful, primarily for treatment counseling, staff safety and better supervision. The other half question the value and costs of testing.

## Issues Involved in Testing

The issue of HIV testing in community corrections—particularly mass screening—is extremely controversial. Testing can be done in several ways: mass screening at the initiation of parole or probation; testing of high-risk behavior groups (homosexuals, IV drug users, sex offenders); testing in response to incidents in which transmission may have occurred; voluntary testing; and anonymous testing as part of epidemiological or public health research.

The debate surrounding testing of parole or probation service populations in many ways mirrors that regarding the general population. But community corrections supervisors are particularly vulnerable to potential liability for release of an infected person into the community. In addition, they may be liable for the potential leaking of confidential test information. For example, probationers or parolees may face stigmatization and discrimination if their HIV antibody-positive status is disclosed. Officers, on the other hand, may be liable to third parties as a result of non-disclosure of information.

As these results suggest, the issue of testing parole and probation populations engenders considerable debate. Some practitioners feel that it is important to know the HIV status of persons under supervision for several purposes: to protect staff from possible transmission; to protect public safety, including the sexual partners of HIV-infected individuals or others in community facilities; and to prepare for managing the individual's incipient illness. The advocates of targeted or mass-testing of groups such as IV drug users argue that seropositive individuals should be identified in order to focus educational and informational services. In addition, testing proponents feel that staff need to know which persons under supervision are seropositive, in order to take special precautions in dealing with them and to help manage their transition back into marital and community life.

Critics of testing argue that the transmission of HIV to staff is a moot issue, because the behavior necessary for effective transmission is unacceptable in the first place. In addition, opponents point out that testing, which is expensive, would have to be repeated periodically to insure that the infected persons were actually identified. Without repeated testing, a false sense of security might develop for those not yet identified—encouraging community corrections officers to be more lax in standard search or cleanup procedures. Finally, the rate of false positives produced might present more difficulty for supervisors than would other proactive methods of identification of high-risk individuals, such as careful history-taking and medical examination. Appendix C contains one such health examination protocol used in Iowa correctional facilities. This exam pays particular attention to lifestyle indicators reported and physical indicators of HIV picked up in pharyngeal, anal, and lymph node examination.

Mandatory screening programs may not be possible in many states under existing statutes. Laws in California, Washington, D.C., New York, Wisconsin, and Massachusetts, for example, prohibit testing without the informed consent of the subject. Case law is continually developing in this area and will be discussed in following chapters. In addition, the right to refuse testing may be legally viable, if it is argued that disclosure of results could have serious negative consequences for such things as insurance benefits, employment opportunities, or family relations.

## How Costly is Testing?

The final question in the debate about testing is that of cost. The ELISA tests across the country as reported in NIJ's AIDS in Correctional Facilities report range from $2 to $38 and average $13 per test.[9] The Western Blot test averages about $41 per test with a range of $2 to $99 reported. The Western Blot adds considerably to the cost of testing, particularly if a large number of persons tests positive on the ELISA sequence. However, laboratories may offer a low flat rate of under $10 for the total sequence, particularly if the positive rate on the ELISA is expected to be low.

Clearly, screening a large number of parolees or probationers could be quite expensive. If an agency has even 1000 persons under supervision and obtains a flat rate for the test sequence of $5 per test, the cost of one-time testing is $5000. That test would need to be repeated at three- or six-month intervals to insure both that new transmission had not occurred and that persons initially seronegative but infected had tested positive. Even a conservative test schedule of two times per year for the population of 1000 would produce substantial costs, which would have to be balanced against both the perceived benefits of testing, and also the opportunity costs. These include resources that could have been spent on education or counseling.

## Summary and Recommendations Concerning Testing in Probation and Parole

Evaluation of whether and under what circumstances to test in community corrections involves questions we will summarize below. Each jurisdiction should weigh these questions carefully before deciding how to address this issue.

- ***Who else is testing in community corrections and what is their experience?***

  At the time of the NIJ survey, only one state and the Federal prison system were conducting mass screening of parolees. However, many others were currently conducting or planning to conduct selective screening soon. Respondents usually described selective screening as one or more of the following: testing in response to an incident involving the potential for transmission, testing because the individual is showing possible symptoms of AIDS, or voluntary testing.

  Those who report no testing and no desire for testing cite as their reasons both costs and fears of confidentiality problems.

- ***Is it possible to maintain confidentiality in community corrections?***

Proponents argue that clients' privacy can be assured by strict adherence to confidentiality procedures. Such procedures involve controlling all access to test information, maintaining separate files, and/or removing all mention of HIV tests from corrections records.

Opponents of mass testing argue that it is impossible to maintain this information in a system in which multiple supervisors may have access to an individual's file. Transfers to other areas or split-sentence cases, for example, add additional parties to the information chain. While an AIDS diagnosis may be part of someone's file due to clinical symptoms of the illness, they argue that adding the additional confidentiality burden of HIV test results is unwarranted.

- ***Can screening work with education programs to increase cooperation of probationers and parolees and better allocate resources?***

Proponents argue that educational resources would be more useful if targeted to those persons testing seropositive. In addition, persons identified as positive can take necessary steps to avoid transmitting the disease to others.

Opponents argue that linking education programs to mass-screening results ignores the fact that many infected individuals may not yet test positive. Consequently, testing fails to identify the total HIV-infected population. More important, education programs must be widespread and widely available to control transmission. Finally, persons who are identified as HIV antibody-positive may not respond well to educational messages if they have been singled out for attention. This group may feel less threatened if addressed as part of a larger, only potentially infected group.

- ***Is mass screening the only way to determine the extent of the AIDS problem in community corrections?***

Proponents argue that mass screening is the only way to determine the scope of the problem and to make sound budgetary decisions based on this knowledge.

Opponents argue that blind epidemiological tests on representative samples of probationers or parolees in each jurisdiction can provide the same information at a lower cost.

- ***Will mass testing improve the delivery of timely medical care to probationers and parolees?***

Proponents argue that early identification of seropositive individuals will help signal the need for special medical referrals or special residential placements of those infected. If treatments become available which slow the progress of the disease even for those with early-stage AIDS, then early identification will be important.

Opponents argue that the majority of seropositives are not ill and not in need of special medical care, especially since neither a cure nor an approved medication to slow early-stage AIDS is currently available. As symptoms of illness appear at varying times for seropositives, it is not possible to predict medical needs based only on HIV status. Finally, placing seropositives in special residences or giving them special treatment may be discriminatory and illegal in some states.

## NOTES

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2. *Ibid.*
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5. *Ibid.*
6. Michael J. Barry et al., "Screening for HIV Infection: Risks, Benefits, and the Burden of Proof," *Law, Medicine and Health Care*, December 1986: 14:259-267.
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8. *Bulletin of the Federal Courts*, December 1987.
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# Chapter 4: AIDS EDUCATION AND TRAINING IN COMMUNITY CORRECTIONS SERVICES

As in the general population, education and training are the cornerstone of any efforts to prevent the transmission of AIDS and to serve both infected probationers and parolees and those who interact with them. Preventing transmission of the virus from probationers and parolees to spouses, staff, or others, is of great concern to corrections agencies. Unfortunately, mass AIDS education is still rare among community corrections services. This is often because agencies fail to recognize each person as a potential HIV carrier. AIDS education for probationers and parolees often consists of post facto, case-by-case counseling, or referrals to community AIDS education or health organizations. On the positive side, however, educating staff about AIDS is a growing practice, and even a priority, of many community corrections services.

The agencies that do not provide AIDS-related education to staff and/or clients cite the following reasons: they have no known HIV seropositives or AIDS cases; their agencies and officers are overburdened; or the problem is too recent. While these reasons may seem compelling, many stronger arguments exist for mandating AIDS education and training. This chapter describes examples of AIDS education and training approaches used around the country, and proposes methods of dealing with the growing concerns of probation and parole agencies.

## Education for Probationers and Parolees

Though the majority of community corrections agencies provide no comprehensive AIDS education for clients, two-thirds expressed a need for such education. Figure 4.1 summarizes the modes of instruction reported by parole and probation services. Currently, community corrections services who supply clients with AIDS education in the form of brochures focus their efforts on those who request the material or those known to be members of high-risk groups. Probationers or parolees usually pick up the materials in waiting areas or upon meeting their supervising officers at the community corrections office. Most of the brochures distributed have been developed by external organizations, such as national and local public health departments, or the state department of corrections. Topics most frequently covered by the educational materials include facts about HIV transmission, medical information about AIDS, and listings of relevant, accessible community resources.

Several community corrections services employ written materials discussing safer sex practices, but only a few use brochures covering procedures for cleaning and disinfecting hypodermic needles and other equipment ("works") of IV drug users. The probation division of Austin-Travis County, Texas, distributes wallet-size cards listing "Safer Sex Guidelines," AIDS hotline phone numbers, and information on the current number of AIDS cases in Austin.[1] California's parole division hands out pamphlets, with concise messages that are appropriately targeted. Pamphlets include: "AIDS Kills Women and Babies,"[2] which contains AIDS hotline and other phone numbers for those in and out of jail, and "Facts About AIDS and Drug Abuse."[3]

The better pamphlets define any technical terms used, such as "condoms" and "syringes," in popular jargon, e.g., "rubbers" and "works." Some of these excellent, simple, and straightforward materials also contain street language for drug users. One brochure provides National Institute on Drug Abuse phone numbers for referral to drug treatment programs. Spanish-language versions of many brochures also exist, including a cleverly designed and very frank double-sided Spanish-English one, "Alcohol, Drugs & AIDS/Alcohol, Drogas y AIDS," used by the probation division of Contra Costa County, California.[4] Examples of some of these materials and information on obtaining them can be found in Appendix E.

Live AIDS education, broadly defined as any instructional mode beyond distribution of written materials, is almost nonexistent for probationers and parolees. In the handful of localities where live education is provided, it takes the form of general information on HIV transmission or, in one case, on drug diversion programs. Only a few of these community corrections services allot time during an information session for questions and answers. A handful of community corrections services employ videotapes; those who do not cite several reasons, usually a lack of available funds or no need perceived. Two community corrections services enlisted clients in program development by requesting their suggestions and including them in an AIDS video.

Figure 4.1

## MODES OF AIDS EDUCATION AND TRAINING PRESENTATION FOR PROBATIONERS, PAROLEES, AND AGENCY STAFF

PROBATIONERS/PAROLEES

| | Parole Agencies N = 55 | | Probation Agencies N = 80 | |
|---|---|---|---|---|
| Mode of Presentation | n | % | n | % |
| • Live Education | 2/43* | 4.7% | 4/63* | 6% |
| • Brochures | 13/43* | 30 | 16/63* | 25 |
| • Videotapes | 2/40* | 5 | 5/62* | 8 |

AGENCY STAFF

| | Parole Agencies N = 55 | | Probation Agencies N = 80 | |
|---|---|---|---|---|
| Mode of Presentation | n | % | n | % |
| • Live Education | 36/41* | 88% | 44/63* | 70% |
| • Brochures | 29/40* | 72.5 | 54/64* | 84 |
| • Videotapes | 25/40* | 61 | 35/63* | 55 |

*Denominator represents number who answered question. Denominators differ due to differences in number of agencies reporting on each mode and to use of multiple modes.

Source: NIJ Survey on AIDS Issues for Probation and Parole.

Agencies which create their own videos on AIDS, more tailored to IV drug users, for example, might supplement these with any of a number of general AIDS videos on the market. Two videotapes suggested for use with probationers and parolees are "AIDS: A Bad Way to Die," produced by and for inmates but applicable to community corrections, and "Dying for Love," a general audience video aimed at women's concerns, such as transmitting the virus to one's fetus.[5]

The Treatment Alternative to Street Crime (TASC) Program in Cook County, Illinois is developing an education/intervention strategy called "Brief Risk Intervention (BRI) which provides information to those identified as possible high-risk clients.[6] During a brief interview and intervention sequence, the officer identifies high-risk activities or health problems, outlines risk reduction strategies, and provides other relevant information.

About one-fifth of community corrections services make some educational materials, such as general brochures or information sheets, available to families or sexual partners of probationers and parolees. A few agencies also make live education and/or videotapes available to them, although none regularly schedule programs. As with AIDS education for clients and officers, providing third parties with such instruction can lessen the potential liability of an agency to those parties.

## Education/Training For Staff

As Figure 4.1 indicates, of the community corrections services offering AIDS education to staff, about half provide it in the form of brochures or other written materials, often distributed during training sessions or at staff meetings. Most of these materials are derived from or distributed with existing materials put out by public health organizations, commercial enterprises, other states, or federal agencies. The Massachusetts Parole Board distributes pamphlets to officers on topics ranging from precautionary measures to counseling parolees known to be HIV antibody-positive. These pamphlets include "AIDS and Your Job: Are There Risks?" and "If Your Test for the Antibody to the AIDS Virus is Positive."[7]

The New York State Division of Probation has developed an exemplary notebook of information and supervision guidelines for parole officers and administrators.[8] Divided into 10 sections, the book covers general information about AIDS, a review of state policies, common questions and answers, and detailed directions for use of referral sources with specifics on how to help individuals apply for special services.

Community corrections services who do not provide staff with brochures offer the following reasons: their materials are awaiting approval by management or a central agency; their materials are still being developed; or their agency uses educational methods other than written materials.

Three-quarters of community corrections services provide their staff with live training on AIDS, from lectures to classroom instruction and seminars. The most popular format consists of general information about AIDS presented in a lecture, brochures, and/or a videotape. Variations include holding one-time workshops or showing a videotape or slides followed by a question-and-answer period. A majority of community corrections services allot some time for questions and answers, anywhere from 10 to 50 percent of session time. Approximately half of community corrections services employ videotapes in education programs for staff. Several services noted the unavailability of videotapes, especially ones geared to the concerns of community corrections. Although videotapes expressly tailored to community corrections are presently not available, videos for general correctional audiences abound. For example, Idaho shows videos, approximately 30 minutes long, such as "AIDS: A Bad Way to Die," "AIDS: The Challenge for Corrections,"[9] and "Information for Law Enforcement Officers."[10]

Community corrections services across the country use different types of trainers for their live programs, the most common trainers being in-house staff, medical experts, and state or local health officials. The New Jersey Probation Services Training Unit has, with good results, used trainers from the state's Department of Health to reduce staff fear and anxiety by providing up-to-date information on AIDS. A few services contract with outside consultants to provide AIDS training. Kentucky's Corrections Cabinet, which includes the Division of Probation and Parole, hires professional AIDS trainers to equip counselors with the knowledge and empathy required for counseling releasees.[11] Missouri's Department of Probation and Parole plans to give similar lessons designed to alleviate fear from the working relationship between officer and HIV-infected probationer or parolee.[12] About a third of community corrections services involved their own staff in the development of the agency's AIDS education program. Staff contributions ranged from working within a task force on AIDS instruction to designing and carrying out the entire program. Only one or two jurisdictions involved a staff union in the development of their AIDS education.

The length of these education and training sessions ranges, depending on the mode and format, from 45 minutes to four hours. New York State's Division of Probation and Correctional Alternatives employs local health agencies to present three hours of regional staff training on AIDS-related subjects. These include safer sex, and counseling techniques, including helping families deal with the disease or death of a relative. Education and training classes among community corrections services are usually given once a year, although a few agencies offer two or more sessions at intervals. Some community corrections services hold sessions at hiring or initial training of staff. Other jurisdictions determine session frequency and timing on the basis of need. Attendance at training sessions is mandatory in approximately one half of community corrections services.

## Staff Training on Advocacy, Referrals, and Resource Coordination

The most successful community corrections' AIDS education and training programs for staff present information and techniques for advocacy, referrals, and resource coordination. Good programs also include units on resources available for AIDS counseling, testing, medical care and other services. Because programs do and will vary from state to state, "program" in this context means anything from the dissemination of brochures to the live presentation of AIDS information.

In dealing with AIDS, the principal task for community corrections is resource coordination: between staff and clients; institutional/court staff and field staff; staff and community organizations; and staff and government agencies. The best programs provide probation and parole officers with articles on traditional and experimental counseling techniques and provide clients with tapes directing them to the appropriate services. Missouri's Department of Probation and Parole is currently working on a manual that contains excerpts from Elisabeth Kubler-Ross' writings on death and dying and other researchers' psychological analyses of HIV-infected IV drug users. In comprehensive programs community corrections staff are trained to act as central switchboards, serving as generalists who refer clients to specialized resources such as HIV testing centers, drug treatment programs, Social Security (SSI) administrators, and hospices. Agency management can play a pivotal role by gathering information on services and local organizations and by facilitating staff contact with these other resources.

The Maricopa County, Arizona community corrections service has established a relationship with the Arizona Stop AIDS Project (ASAP), a community program offering people with AIDS (PWAs) assistance with applications to social services such as SSI and food stamps; referrals to doctors, lawyers, and priests; financial assistance (through grants and loans) for rent and utilities; and emotional support through volunteers and support groups, for the PWA and the family. They also offer a housing/hospice program. Parolees and probationers, particularly those who are IV drug users, often lack adequate social support systems or the motivation and knowledge to seek out public support. As liaisons, community corrections staff take the initiative to explore available benefits appropriate for their clients. For example, those who are HIV seropositive or who have ARC but not full-blown AIDS may not automatically qualify for SSI and may need trained guidance in this area.

San Mateo County, California, has developed a Buddies Program, which pairs PWAs (and also people with ARC) and their families with a trained resource and support volunteer. The Buddies Program exemplifies coordination at its best: San Mateo community corrections officers can refer clients with AIDS to Buddies. Buddies is a program of ELLIPSE (Peninsula AIDS Services Inc.) which works with the San Mateo County AIDS Project of the Department of Health Services.

Not all locales may have an ASAP or a Buddies Program, but similar community resources exist in many areas. Where they exist only in neighboring vicinities, staff might help clients establish contact with nearby self-help organizations.

## Role of Agency Management, Correctional Institutions, and Courts in Facilitating Education/Training

Effective AIDS policies never sacrifice consistency for caution. Promulgating agency policies and procedures that incorporate extreme precautions contradicts the stated purpose of education programs, which is to dispel irrational fears. For example, education programs for law enforcement officers continually emphasize the point that transmission cannot occur through casual contact. Yet in some jurisdictions, law enforcement officers may be issued gloves—without specific guidelines for their use. Some law enforcement personnel have even requested the HIV antibody status of probationers or parolees with outstanding warrants, indicating that the officers believe special precautions should be taken in apprehending them.

These inconsistencies illustrate the potentially dangerous belief that the only individuals with whom it is necessary to take precautions or who need counseling are those *known* to be members of high-risk groups or those *known* to have ARC or AIDS. A probationer or parolee who is, unknown to the supervising officer, the sexual partner of an HIV-infected individual, carries the same minimal risk of viral transmission to staff as does the probationer or parolee openly suffering from AIDS. The officer might be wary around the latter individual but would not know to take the same precautions, such as avoiding blood-to-blood contact, with the former individual. It bears repeating both in agency policy memoranda and in AIDS education programs, that any client, or even any officer, may be a carrier of the virus and that certain high-risk *behaviors*, rather than high-risk *groups*, should be of primary concern. A few universal precautions should be the standard.

No community corrections educational response to AIDS can be carried out without the commitment of agency management. Given the great investment of time and funds required for thorough AIDS education and training programs, management support is essential. Consulting with legal counsel and notifying officers about their jurisdiction's particular health-status disclosure regulations and other relevant laws is clearly an important role for agency management.

Agency heads can also act to relieve the enormous tensions brought on officers by the presence of HIV-infected persons in caseloads. Exemplary of such foresight, the New York State Division of Probation and Correctional Alternatives urges its local probation departments to establish informal support systems to help staff bear up to the stress of caseloads containing many high-risk or HIV seropositive clients.[13]

New York's policy directive on AIDS asks management to ensure that staff fears about HIV transmission do not drive staff to such extreme measures as replacing face-to-face contacts with phone contacts. It states that only in the case of a client too sick with AIDS to visit the office, or other circumstances deemed extenuating by the court, would phone contacts be an acceptable deviation from probation or parole conditions. Since New York State's is a decentralized, county-based probation system, this umbrella organization can only offer guidelines to local departments. However, these suggestions, although not binding, form a very helpful framework within which staff of local departments can make their decisions and judgments.

Both the New York State Division of Parole and the Division of Probation and Correctional Alternatives have published excellent guidelines on AIDS, with topics ranging from informational resources (including a map of New York State AIDS Task Forces and a phone list of SSI Teleclaims offices) to a section of questions and answers specifically relating to community corrections. The following are examples from New York State materials:

> *Question:*
>
> Does the Division have money to help parolees with AIDS with the cost of housing or other expenses?
>
> *Answer:*
>
> The Emergency Support Fund and Emergency Housing Funds established in each area office exist to assist parolees in need of housing, transportation, and other assistance. Funds can be accessed in accordance with local area office procedures.
>
> *Question:*
>
> Is a probation officer prohibited from routinely questioning defendants and/or probationers on their sexual preference, intravenous drug use, and whether they have AIDS or are a carrier (seropositive)?
>
> *Answer:*
>
> While questioning is not barred, it is nevertheless . . . highly sensitive in nature and therefore it is not recommended . . . . Should a defendant or probationer volunteer this information, further questioning would not appear inappropriate. If a probation officer has contact with [a member of] any of the high-risk categories, s/he should consider providing information (i.e. brochure, hot line number, testing sites) and encourage such individuals to seek counseling and testing.[14]

Kentucky's Division of Probation and Parole also sends its staff members memoranda containing highly pertinent AIDS-related questions and answers, such as:

> *Question:*
>
> Do we have a liability to notify employers/family members when AIDS is detected in probationers or parolees?
>
> *Answer:*
>
> No such liability exists, and current legal opinion seems to point to the fact that we would be placing ourselves in a liable position with the client should we disclose the information.[15]

Many community corrections departments are capitalizing on the AIDS education programs in progress for inmates and pre-parolees at various correctional institutions. Three community corrections services say that they require AIDS education as a parole condition for parolees who are HIV-infected or have ARC or AIDS. Colorado's Department of Corrections, like several other states, educates seropositive pre-parolees before their release into parole or community placement. Georgia's Board of Pardons and Paroles has established 10 special conditions of parole for those who are HIV antibody-positive, and has created an acknowledgment form which these individuals must sign. The parole conditions consist of: pledges to refrain from "risky" behavior, such as tattooing and selling blood; permission to disclose HIV antibody-positive status to prospective co-residents; and proof, via oral or written exam, of thorough knowledge about the disease, precautions, and health management. Such an AIDS policy requires a close working relationship between institutional parole and field parole officers and an equally communicative relationship between field officers and collateral contacts. (For examples of the Georgia forms, see Appendix G.)

Attempting to bring together probationers and/or parolees who may be scattered throughout the community and may not be grouped in residential placements is difficult. However, there are ways to facilitate such group AIDS classes. For example, judges may as a condition of probation order probationers to attend special AIDS classes which community corrections services arrange through their chapters of the Red Cross, local AIDS Action Committees, or other groups. Some judges in Cincinnati, Ohio have already adopted this approach, by requiring as a sentencing condition that IV drug users and sex offenders participate in a special two-hour class on avoiding exposure to AIDS.[16]

## Frequent and Mandatory Mass AIDS Education for Probationers and Parolees

The epidemic nature of AIDS requires repeated and mandatory education for probationers and parolees. Up to now, most community corrections services have been working within their existing system of reporting and supervisory contacts to encourage known IV drug users to be tested for the virus or to urge individuals with apparent symptoms of ARC or AIDS to undergo a complete medical examination. This reactive approach, which may be adequate for a jurisdiction with few HIV-infected individuals, will fail community corrections services as more IV drug users and other high-risk clients either become seropositive or develop ARC or AIDS. Besides not reaching the larger population of those who are potentially or presently (but unknown to the officer) HIV seropositive, these case-by-case efforts undoubtedly reach only a fraction of those with manifest ARC or AIDS. Therefore, it is suggested that community corrections services supplement this form of AIDS education with a proactive approach: live training, or at least distribution of written materials to all clients. Arranging classes for probationers and parolees is not a simple task, especially for those whose sentences do not include residential placements. But solutions can be found with proper planning, support, and coordination. Several of the community corrections services consider the AIDS education that parolees have had as inmates sufficient for their tenure as releasees. This policy ignores the necessity of repetition and the importance of tailoring education to specific audiences. A parolee's behavior and concerns, like those of a probationer, are different from those of an inmate. Community corrections' liability is likewise different from institutional liability. Therefore, past classes in prison will not suffice for parolees; random and occasional referrals to community organizations will not suffice for probationers. AIDS requires a thoughtful and comprehensive educational effort.

Unlike correctional facilities, which need to avoid alarmism in their AIDS education, community corrections services might do better to stimulate concern among clients. Parolees and probationers may lack the fear of HIV transmission which confinement inspires in inmates. Furthermore, those not incarcerated come into contact with many more members of society whom they could potentially infect or be infected by. It is for these reasons that agencies should convey the harsh realities of the high rate of HIV transmission and of a lingering AIDS death, especially among IV drug users.

At the same time, community corrections services must strike a balance in their presentation to avoid discouraging those who might be HIV antibody-positive from being tested. For example, some California county probation departments, such as San Diego County, give clients bulletins or booklets describing antibody testing at alternative test sites. These materials present the pros and cons of taking the test, discuss anonymity and confidentiality, talk about the interpretation of test results, and draw the distinction between testing positive for antibodies to HIV and actually having ARC or AIDS. The bulletins answer in clear and concise language such thorny questions as:

> *Question:*
>
> If there is no known cure for AIDS, why should I have the test?
>
> *Answer:*
>
> After learning all the facts, you may decide that you do not want the test. However, you

may want to consider taking the test if you are in one of the high-risk groups discussed above. Results of the test along with appropriate education may help guide you in what precautions you should take to protect your health and the health of others.[17]

To summarize, the following are key elements of successful AIDS education and training programs, both for officers and for probationers and parolees:

- education that is timely, regular, and mandatory;
- programs backed by the commitment of agency management;
- staff and client participation in initial and ongoing program development;
- programs that employ live presentation, including a talk, question-and-answer period, videotape, and/or slide show, plus written materials, such as brochures or memoranda;
- education that puts forth simple and straightforward messages targeted, in both content and language, to the appropriate audience—more technical for officers, more colloquial for clients;
- programs that maintain credibility by using knowledgeable and approachable presenters, peer trainers, and accurate materials prepared by national organizations;
- for direct protection from agency liability, documentation of program attendance and/or receipt of written educational materials.[18]

Strategic planning of a good AIDS education program requires time and money. Any measures instituted by an agency will ultimately be determined by available resources, but a variety of resources can be used, including outside agencies and local support groups.

## Policy Recommendations

Although it is best to plan and institute educational programs on AIDS before the first case is encountered and before worries surface among clients or community corrections staff, it is never too late to begin. By mid-1988, many community corrections services will have encountered and dealt with at least a few HIV antibody-positive and some AIDS-afflicted clients.

This chapter has discussed the key issues in AIDS education and training. The answers to the following questions summarize our recommendations:

- ***Whom should AIDS education and training programs address?***

  AIDS education should be mandatory for all community corrections staff and for all probationers and parolees. In addition, all staff should receive training in how to manage AIDS patients in their caseload. Where possible, educational materials and programs should be made available to spouses or family members of HIV-infected clients who wish to participate.

- ***What are the most effective education and training programs?***

  Programs which are live, and use up-to-date information presented in a simple, easy-to-understand fashion are most effective, especially when they include question-and-answer periods. Where possible, role-playing issues or situations reinforces the message. Peer training is also an effective use of available resources.

- ***How often should such programs be given?***

  Programs which are updated and repeated periodically have more potential for producing results than those given once or twice. For example, the distribution of generic materials at one point in supervision or training should not be expected to have lasting value.

- ***Why should our agency train specifically for AIDS?***

  AIDS has captured the fears of the population in a unique fashion. This fear has produced misinformation about the disease and its transmission in all quarters, including criminal justice. To deal calmly and effectively with the clients coming through an agency, both the staff and the clients need to be well-informed and trained. Finally, preparedness is the best protection against liabilities related to supervision of probationers and parolees. Agencies may, through documented education and training programs, counter claims that training or information they provided inadequately protected staff or third parties.

## NOTES

1. "AIDS Services of Austin—Safer Sex Guidelines," AIDS Services of Austin, March 1987.
2. "AIDS Kills Women and Babies," San Francisco AIDS Foundation and San Francisco Department of Public Health Jail Medical Services.

3. "Facts About AIDS and Drug Abuse," American Red Cross and the U.S. Public Health Service, October 1986.

4. "Alcohol, Drugs and AIDS/Alcohol, Drogas y AIDS," San Francisco AIDS Foundation and Department of Public Health, July 1986.

5. "AIDS: A Bad Way to Die" (videotape). Copies available without charge by sending a blank VHS cassette with self-addressed mailer to Charles Hernandez, Superintendent, Taconic Correctional Facility, 250 Harris Road, Bedford Hills, NY 10507, (914) 241-3010.

   "Dying for Love" (videotape, $40). Available from Lifetime Productions, Inc. (212) 719-7162.

6. "Brief Risk Intervention," Cook County, Illinois. Draft. 1988.

7. "AIDS and Your Job: Are There Risks?" and "If Your Test for the Antibody to the AIDS Virus is Positive," American Red Cross and the U.S. Public Health Service, October 1986.

   "Straight Talk About Sex and AIDS," San Francisco AIDS Foundation and San Francisco Department of Public Health, 1987.

   "AIDS Kills Women and Babies."

8. *AIDS Policy Guidelines for Probation Departments and Alternative Programs*, Division of Probation and Correctional Alternatives, Executive Department, State of New York. Notebook.

9. "AIDS: The Challenge for Corrections" (videotape). Developed by National Sheriffs Association (NSA); $25 to rent or $110-175 to purchase; available in Spanish or English. NSA, 1450 Duke St., Alexandria, VA 22314; (703) 836-7827.

10. "Information for Law Enforcement Officers" (videotape). Available from San Francisco Police Department (415) 553-9777, or from AIDS Hotline (415) 864-4376, x2036.

11. "AIDS Memorandum No. 1," Commonwealth of Kentucky Corrections Cabinet, February 14, 1986.

12. "Training Curricula," State of Missouri Department of Corrections and Human Resources, March 1988.

13. "AIDS Policy Guidelines for Probation Departments and Alternative Programs," Division of Probation and Correctional Alternatives, Executive Department, State of New York, Albany, N.Y., 1987.

14. *Ibid.*

15. "AIDS Memorandum No. 1," *op. cit.*

16. "Justice Policies," State Capitals Newsletter (New Haven: Wakeman/Walworth) August 17, 1987: 41:33.

17. "Questions and Answers About the HIV Blood Test," County of San Diego Department of Health Services, April 1987.

18. T.M. Hammett, *AIDS in Correctional Facilities: Issues and Options, Third Edition* (Washington, D.C.: National Institute of Justice, U.S. Department of Justice, 1988).

# Chapter 5: CONFIDENTIALITY, LEGAL, AND LABOR RELATIONS ISSUES

This chapter is divided into three sections. The first examines the issue of notification and disclosure, that is, who receives or should receive information on the HIV status of individuals under community corrections supervision. The second discusses the growing case law on AIDS as it applies to probation and parole departments. The concluding section provides summary guidelines for developing policies to protect confidentiality and minimize the liabilities of parole and probation services.

## Notification and Confidentiality

The need to form policies regarding disclosure of HIV antibody test results and notification of an AIDS or ARC diagnosis gives rise to some of the most pressing decisions that parole and probation services face. Community corrections staff often argue that they have both a need and a legal right to know test results, because of the perceived health risks associated with not knowing, the potential liabilities for failing to provide necessary services, and the failure to notify and thus prevent HIV infection of a third party. Seropositive individuals conversely assert their right to privacy. While there have been no cases brought specifically against community correction agencies or officers, it is reasonable to assume that indiscriminate circulation of a client's HIV status might entail a serious risk of liability.

Decisions regarding confidentiality and disclosure may be governed by state law or policy standards. California, for example, requires written authorization to release test results or other medical records. More often, however, there is room for discretion, and community corrections services face conflicting demands.

Community corrections administrators may feel a need to know test results in order to make informed classification and programming decisions. Probationers or parolees suffering from AIDS or ARC often do have special needs in obtaining medical attention, employment, housing, counseling, or other support services. In these cases, officers may have a legitimate need to know in order to secure the necessary services. Notification to public health departments, other agencies within community corrections (such as residential facilities), or third parties, such as spouses, sexual partners, employers, or family are all considered important in releasing clients into the community responsibly. Disclosures may also reduce the system's legal liability should a probationer or parolee transmit HIV infection to others.

On the other hand, the most compelling reason for maintaining confidentiality is that persons known to have AIDS, ARC, or asymptomatic HIV infection may suffer discrimination in employment, housing, or insurance coverage, as well as possible ostracism by the community, family, or friends. Again, there is also the danger of complacency or a false sense of security if it is assumed that all those infected have been identified. By contrast, if "universal" blood and body fluid precautions are routinely followed, knowledge of antibody status will be unnecessary to protect staff from infection.

## Overview of NIJ Survey Results

As preceding sections have reported, there are only a handful of community corrections systems that are currently testing or planning to test clients for HIV antibodies. Only three agencies currently do any systematic testing of parolees and two others are considering instituting testing. Five probation systems currently test some probationers and five plan to begin selective testing programs in the future. As discussed in Chapter 3, however, most agencies do have access to test information from other sources. Thirty percent of the systems surveyed have access through prior incarceration records and 21 percent have access through medical reports.

Few community corrections systems have specific policies regarding the disclosure of HIV antibody test results. Only 21 percent of the probation agencies and 16 percent of the parole systems answered questions concerning disclosure of clients' HIV antibody test results. Again, it must be emphasized that the lack of a response to this question cannot be assumed to indicate a lack of a policy. Survey results indicate that when this information is available, some parole or probation officers, physicians, other medical staff, and departments of public health will be informed. Seven percent of the systems surveyed formally inform the officer and 5 percent formally notify the attending physician. Seven percent surveyed officially notify the department of public health, as is often required by law. Only one probation system and one parole system—both in Georgia—routinely disclose this information to an individual's spouse or family, and no systems report that they inform employers.

## Range of Legal Options Regarding Who Receives Information

Sixteen states reported state laws governing notification. The laws vary widely in their restrictions on disclosure, from severely limited to more lenient.

Many states, including California, Florida, Illinois, Massachusetts, Oregon, and Wisconsin, have very restrictive laws regarding disclosure of HIV antibody test results. Under California law, only the subject is entitled to the results of the test unless he or she provides written authorization for their disclosure; written consent is also required for each subsequent disclosure. Without written consent, no one may identify the subject or divulge the results of any test. Test results are not subject to disclosure under California's employer "right-to-know" law and may not influence any decision regarding employment or insurability. In California, for example, blood banks and plasma centers submit monthly reports summarizing data concerning HIV antibody tests, but reference to the identity of individual donors is prohibited.

Under Wisconsin's law, only the subject, the subject's physician, laboratory personnel or other staff of health-care facilities, and the state epidemiologist can legally receive results of HIV antibody tests. A court order is required for all other disclosures. Therefore, in states such as California and Wisconsin, community corrections staff who are not health-care personnel have no right to obtain test results.

Medical staff, in particular an individual's attending physician, have an obvious need to know HIV antibody test results for diagnostic and treatment purposes. These individuals are in a crucial position for maintaining the confidentiality of this information within a correctional environment, as they may be the only persons legally authorized to obtain and disclose this information. If community corrections authorities are notified of a client's HIV seropositivity, the information often comes from correctional medical staff where the individual has been incarcerated.

Many community corrections services argue that both administrators and line officers need to know the results of HIV antibody tests in order to make classification and programming decisions and to protect themselves and the community from infection. The argument that an officer might need to know the HIV antibody test results of an individual under supervision rests on the need for that information in order to provide the necessary services: financial, housing, legal, medical, or counseling. It is essential, however, that policies define carefully who needs to know what and why. Universal precautions with all clients are adequate for the protection of staff in their day-to-day duties so that officers not associated with a client have no real need to know his or her HIV antibody status.

On the other hand, directly supervising officers concerned about provision of medical services or protection of third parties may feel strongly that they need to know. Because community corrections systems have few and usually broad policies regarding disclosure of information on HIV infection, every effort should be made to formalize procedures as precisely as possible. Vagueness inevitably causes problems, and while it may help protect the agency from liability, it serves only to increase the potential liability of an officer.

Moreover, policies should be both reasonable and enforceable, as an officer may be liable for not enforcing agency guidelines. For example, a condition of supervision prohibiting the transmission of bodily fluids (through unprotected sex, donation of blood, etc.) may place an impossible responsibility on officers to monitor the most intimate behaviors of clients.

Few community corrections services are aware of or could become aware of an individual's HIV antibody status, barring self-disclosure or evidence of either clinical indications or high-risk behaviors. However, most systems require that pre-sentence reports include a description of the offender's mental, psychiatric, and physical condition. In New York State, the investigating probation officer looks for possible signs of AIDS or ARC when compiling such reports. If a defendant states that he or she has AIDS or ARC or if this information is passed on to the officer by a third party, the source and circumstances of the disclosure are recorded, along with an assessment of its reliability. If it is suspected that a defendant has AIDS or ARC, despite the absence of substantiation, guidelines suggest that the officer explain to the defendant why it is important that this information be communicated to the agency, although the officer must be careful not to deny the defendant his or her right to privacy.[1] The New York state guidelines for probation departments are included in Appendix G.

In the case of parole, if the offender has previously been incarcerated, the same prison systems notify the parole board of an individual's HIV antibody status. Although only a few prison systems conduct mass screening, many test on a limited basis—when clinically indicated, on request, or if inmates are believed to be at risk. A number of correctional systems, including Missouri, Maine, Iowa, and New York, routinely notify community corrections authorities of an individual's

HIV antibody status. This information is often included in the medical report, as are diagnoses of AIDS or ARC, to insure treatment or to secure other necessary services.

New York State provides for a formal exchange of medical information. The Department of Corrections provides institutional parole staff with medical discharge summaries. These reports include a diagnosis of the parolee's condition, a reference to living arrangements and employability where dictated by his or her current medical condition, an indication of whether the inmate has accepted his or her condition and is cooperating with treatment, and whether there is any need to develop or continue treatment. The Department of Corrections sends the Director of Parole a list of all inmates diagnosed with AIDS or ARC. In turn, senior parole officers receive a list of all those under parole supervision who have developed ARC or full-blown AIDS.[2]

The notification of the infected individual's supervising officer is based on the need to provide special services. It would be difficult to argue that *all* officers have a right to know when they are working with HIV-infected individuals based solely on a perceived health risk, since AIDS cannot be transmitted through normal officer-client interaction. As long as standard blood and body-fluid precautions are followed, the officer has little or no risk of infection. AIDS education and training and documented precautionary policies can successfully alleviate unfounded fears of HIV infection on the part of staff who are not directly involved in providing services.

## Notification of Other Criminal Justice Agencies, Public Health Departments

Opinions vary on the need to notify other criminal justice agencies. The study highlighted two concerns in particular. One is whether it is necessary to inform residential facilities of a client's HIV antibody status. If these facilities segregate seropositives, disclosure could be required or strongly advised prior to placement. Alternatively, as is the case in Texas, parolees may be required to submit to an HIV antibody test prior to placement, and if they test positive, they may be refused placement. Jurisdictions with such policies defend them as efforts to protect a correctional institution from potential liability should staff or other individuals at the facility become infected. States that have special housing requirements include Wisconsin, Florida, Texas, Colorado, New Hampshire and Georgia. There is, of course, the potential liability from exclusion or special treatment of these clients inherent in this policy.

Another consideration is whether or not community corrections services should inform local police or other law enforcement officers of HIV-infected individuals under their jurisdiction. Some services, including New York, Massachusetts (to a limited degree) and Iowa have made specific provisions for disclosure to local jurisdictions in the event that an individual violates probation or parole and a warrant is filed for his or her arrest.[3] In some jurisdictions, the specific diagnosis may not be revealed, but officers may be warned to "take normal precautions," or they may be given vague disclosures regarding "infectious diseases" or "blood-borne diseases." While technically these warnings maintain confidentiality, since they can apply to diseases other than AIDS, they may in actuality be thinly-veiled codes. Because following "universal precautions" for blood-borne diseases should protect the arresting officer from infection, there may be no real argument in support of such policies.

Six percent of probation systems and 6 percent of responding parole systems routinely notify public health agencies when a client is known to be seropositive. Some states, including Colorado, Nevada, and Louisiana, have laws requiring notification of public health departments. Others, such as California, have laws requiring that summary, statistical information be reported without revealing a subject's identity.

Under the Colorado law, all positive HIV antibody tests must be reported to state and local public health agencies. The law is designed to alert public health authorities to the presence of potentially infectious individuals and to ensure counseling about test results and preventive measures. However, in Colorado, this information is to be held in the strictest confidence and is not disclosed to insurers or employers without permission of the subject.[4]

## Notification of Sexual Partners, Spouses, Employers

Notification of sexual partners presents one of the most difficult problems for supervising officers. Many community corrections administrators feel that they may have a moral responsibility to notify the spouse or sexual partner(s) of probationers or parolees with HIV-related conditions, when there is evidence that the individual will not assume that responsibility. The real question is whether community corrections systems should take on a responsibility that is not required of institutions in the community at large, or whether they should rely on AIDS counseling and education to persuade clients to reveal their status to partners.

Some states require that an inmate give his or her written consent for disclosure to the spouse, in order to be eligible for parole. There are serious legal issues raised by such a policy, since mandated disclosure may contradict a constitutional right to privacy. Instead, in an effort to minimize the risk of liability, some agencies adopt written policies requiring the physician, health-care provider, or officer who may know of an individual's HIV seropositivity to counsel him or her. These providers or officials would advise the individual of the responsibility to inform all sexual partners of his or her medical condition, to use safer-sex techniques and, if relevant, not to share needles and to disinfect them properly.

In cases in which subjects refuse to inform their spouse or sexual partners of their HIV status, the Federal Division of Probation and the American Parole and Probation Association recommend that community corrections officers refer the matter to the public health authorities. However, if after consultation with public health authorities an officer determines a specific, medical risk to a third party, and the public health department is unable or unwilling to make such a disclosure, *and state or local law does not prohibit such a disclosure*, the officer should provide a "discrete and confidential warning."[5]

Recent CDC guidelines similarly suggest that if an infected individual refuses to notify his or her sexual partners, the health-care professional should consider making a confidential disclosure. A recent law in California permits physicians to notify the spouses of HIV-infected persons. Community corrections systems should make sure that they are aware of state and local confidentiality laws before instituting policies governing third-party disclosures. Such guidelines must be precise, avoiding vague wording that leaves decisions to the "discretion of the officer" or to examination on a "case-by-case" basis.

Since AIDS cannot be transmitted casually, an employer cannot argue that a probationer or parolee poses a threat to the health and safety of others in the workplace. It is unlawful for an employer to discriminate against an employee who is HIV antibody-positive, unless that individual is incapable of performing the tasks required of the job. Therefore, there is no need for community corrections officers to disclose HIV status information to an employer. In fact, agencies may be held liable for defamation or invasion of privacy if the probationer or parolee is discriminated against in a work environment or refused employment as a result of the disclosure.

## Legal and Labor Relations Issues

Currently, legal issues pertaining to the treatment of AIDS cases in probation and parole systems are theoretical, as no cases have been filed. However, an examination of the rapidly growing case law on AIDS, in particular as it relates to AIDS in a correctional environment, may clarify the legal issues and liabilities facing community corrections services. This section summarizes case law and legal and labor relations issues raised by probationers and parolees, and by staff.

*Issues Raised by Probationers and Parolees*

- Challenges to parole eligibility
- Discrimination against those with HIV infection/AIDS
- Special conditions for those with HIV infection/AIDS
- Challenges to segregation in residential facilities
- Challenges to HIV antibody testing
- Confidentiality of medical information

*Issues Raised by Staff*

- Community corrections' liability for third-party HIV infection
- Testing in response to potential transmission incidents
- Labor relations issues
- Obligation to perform duties

## Challenges to Parole Eligibility

It has been argued that inmates with AIDS should remain under the correctional system's medical care, without parole or pre-release placement in halfway houses or community-based programs, in order to ensure proper care, to minimize the risk of HIV transmission, and to reduce potential liabilities faced by the system. The question is whether or not a parolee's physical condition should alter sentences which were originally mandated by criminal acts and whether or not there are any legal implications associated with such a policy.

Persons who are mentally ill *and* who pose a threat to society or to themselves may be legally removed from society at large and may be committed for extended periods of time. The case of a person with AIDS, however, is very different as the danger of transmission rests largely on consensual acts rather than forcible victimizations. The violent sexual offender is, of course, the exception; he may require special efforts to ensure rehabilitation prior to release. When determining an inmate's eligibility for parole, it would seem reasonable to make an assessment of his or her medical condition as well as an assessment of the likelihood that he or she would engage in violent or other non-consensual acts by which the infection might be transmitted. However, it is unlikely that medical factors alone could legally warrant extending incarceration.

Early release and executive clemency are being considered by some states as the number of persons with AIDS in correctional facilities rises. No states currently report an early release policy for persons with AIDS, though all may use the discretionary early release provision for illness.

Although it may seem reasonable for an officer to recommend early discharge for a parolee dying of AIDS, such a recommendation, based solely on humanitarian reasons, may not be consistent with criteria established by law. Most states have laws dictating early discharge from community corrections services, depending on whether the individual has diligently complied with the conditions of the sentence, whether his or her release would jeopardize public safety (from criminal behavior, *not* from disease), and whether he or she is in need of continued guidance or other assistance as provided through community corrections services.[6]

While early release of individuals with AIDS or ARC is not necessarily recommended except in special circumstances, there may be legal grounds for establishing such special conditions for those with AIDS, ARC, or asymptomatic HIV infection. Community corrections services could be held liable if, as a result of supervision, a client is subject to conditions that adversely affect health. In this regard, an individual's medical condition might warrant changes or exceptions to supervision requirements. Persons with AIDS or ARC may experience periods of severe debility or illness, requiring hospitalization or periods of recuperation, during which time home visits may be the only reasonable method for making personal contacts. AIDS diagnosis alone is not necessary and sufficient to mandate reclassification, although a client's health may factor into such decisions.

## Discrimination Against Probationers or Parolees with AIDS

In October, 1988, the U.S. Department of Justice was asked to issue an opinion on the scope of the existing anti-discrimination provisions of the federal Rehabilitation Act of 1973. This act prohibits federally funded employers from discriminating against employees with handicaps, provided they are otherwise qualified to work. It was unclear, however, whether both persons ill with AIDS and asymptomatic HIV carriers were protected.

The Justice Department's opinion stated that the first group, those ill with the disease, were clearly protected according to the decision of the U.S. Supreme Court in *School Board of Nassau County v. Arline* (1987). The Court ruled that a contagious disease—in this case, tuberculosis—is a handicap protected by the Act. Notably, the court rejected arguments that fear of transmission was grounds for dismissal:

> "It would be unfair to allow an employer to seize upon the distinction between the effects of a disease on others and the effects of a disease on a patient and use that distinction to justify discriminatory treatment. [The...] basic purpose [of the Act is] to ensure that handicapped individuals are not denied jobs or other benefits because of the prejudiced attitudes or the ignorance of others."[7]

The Justice Department opinion concurred with the Court and took the further position that even asymptomatic HIV-infected individuals should be protected.

The Office of Legal Counsel, which prepared the opinion, said it was guided by information from the Surgeon General. He contends that even asymptomatic HIV-infected individuals are "physically impaired," from a medical standpoint, and adds that the impairment of HIV infection cannot meaningfully be separated from clinical AIDS.[8]

Thus the Justice Department concludes that both those with full-blown AIDS and those asymptomatic but infected are included in the definition of handicapped for the purposes of the Act. The Department mentions further grounds for including the latter group: the Supreme Court concluded in *Arline* that "if a person is perceived by others as having a handicapping condition . . . that in itself could bring the person within the terms of the Act."[9]

In conclusion, the opinion reiterated earlier statements that HIV-infected employees should be treated on a case-by-case basis. So long as they pose no "threat to the health or safety of others [and are not] unable to perform the job," the Department feels employees should receive full federal anti-discrimination protection.[10]

In New York it is illegal to discriminate against a person with asymptomatic HIV infection, ARC, or AIDS. Last year in New York, the state Supreme Court ruled that AIDS is a disability and that individuals with AIDS, ARC, or asymptomatic HIV infection are protected by the New York State Human Rights Law (Executive Law Art. 15) which prohibits discrimination against persons who are disabled or who are perceived to be disabled. AIDS has been characterized as a handicap in several other cases as well.[11]

As the trend is towards treating AIDS, ARC, and HIV antibody positivity as protected handicaps, it would seem that community corrections services must afford those with AIDS all the rights and opportunities available to others, and in particular, that discrimination in housing or employment would be unlawful.

## Special Conditions of Supervision

In an effort to protect themselves from the threat of third-party liability, some agencies suggest imposing special conditions on HIV-infected individuals. Some advocate conditions which prohibit contact with bodily fluids of HIV-infected individuals. However, as we will discuss in Chapter 6, the United States Parole Commission and the Federal Division of Probation maintain that to impose such a condition inappropriately extends the role of community corrections from the prevention of crime to the prevention of disease. Moreover, such a condition places the responsibility on officers to monitor the most intimate behaviors of their clients. As such it is perhaps an unenforceable condition, which serves only to further the liability of community corrections officers in the event of injured third parties. Only one state, Georgia, imposes such specific prohibitions as conditions of supervision.

Some agencies, including Georgia and Tennessee, require that infected clients disclose their status to spouses, prospective sex partners, or other persons in danger of being infected as a condition of parole or probation. A compelling argument against such a condition is that in many states, non-voluntary disclosure constitutes violation of state law. The Federal Division of Probation maintains that mandated disclosure as a condition of supervision by clients who have been exposed to HIV "is an unwarranted intrusion by criminal justice into the public health arena without any medical evidence that it would have any effect whatsoever on the AIDS epidemic."[12] However, the Federal Parole Commission suggests disclosure to third parties at risk in states where it is permissible.

Another condition of supervision used in some states is participation in AIDS education and training for probationers and parolees who are HIV-infected. As previously discussed, under most circumstances community corrections authorities are not permitted to disclose an individual's HIV antibody status to third parties. Thus, identifying persons for participation must be handled judiciously. It may be reasonable, for example, to establish a special condition requiring the successful participation of all clients in AIDS education, counseling, and treatment programs. Alternatively, such participation could be required of persons with a history of IV drug use, or sexual offenses. Unlike other conditions, this one is rehabilitative and supportive in nature, a role with which community corrections authorities may be more comfortable.

## Challenges to Eligibility and/or Segregation in Residential Facilities

Residential facilities and prisons face similar programming decisions when attempting to ensure the health and safety of staff and individuals under their supervision. When dealing with HIV infection and AIDS in a secure environment, systems have a responsibility to protect staff and inmates from transmission. Those who are HIV seropositive must also be protected from threats and possible violence as a result of their antibody status. A brief examination of the existing case law for correctional facilities may clarify potential suits faced by residential facilities.

Many correctional facilities have chosen to segregate inmates with AIDS, ARC, or asymptomatic HIV in response to these concerns and, as a result, have faced suits filed by segregated inmates alleging that conditions of their confinement violate equal protection standards and/or constitute cruel and unusual punishment. Although several cases remain pending, the courts have upheld the discretion of correctional officials to segregate HIV-infected inmates and to deny them access to programs and privileges, such as rehabilitation or work-release programs, in an effort to advance medical, safety, and security objectives. In the context of community corrections, one could envision residential facilities faced with suits filed by parolees challenging their segregation at these facilities or their exclusion from these programs as a result of their HIV antibody status.

In *Cordero v. Coughlin*,[13] a group of segregated inmates with AIDS sued the New York State Department of Correctional Services alleging cruel and unusual punishment, deliberate indifference to their serious medical needs, and deprivation of equal protection of the laws, claiming that the conditions of their confinement produced depression and decline in their medical condition. The plaintiffs also argued that even though they had no absolute right to such things as rehabilitation programs, exercise or visitation, they were nonetheless entitled to equal access to those programs. The court held that inmates have no constitutional right to freedom from segregation enforced to further a legitimate institutional objective, in this case preventing HIV transmission. Any equal protection claims were denied because the court did not consider inmates with AIDS to be "similarly situated" as other inmates in the institution, as required by the constitution.

A similar suit was filed in an Oklahoma case, *Powell v. Department of Corrections.*[14] In this case, an HIV antibody-positive but asymptomatic inmate alleged that he was segregated from the general prison population and denied access to worship services and exercise. Despite the different medical conditions of the plaintiffs, the court reached the same conclusion as in *Cordero* that the segregation policy sustained correctional objectives of protecting staff and inmates from HIV infection. In addition, the court asserted that inmates have no constitutional right to be in the general population and that the inmate was not denied equal protection, as he had not been treated differently from other seropositive inmates, even though he was the only identified seropositive inmate in the prison system.

In *Marsh v. Alabama Department of Corrections,*[15] an inmate alleged that he was unconstitutionally segregated and disqualified from work-release programs as a result of his HIV seropositivity. Citing *Cordero* and *Powell,* the court ruled in favor of the Alabama correctional system. Case law is quite extensive in this area and follows the patterns of the cases described here.[16]

In light of these decisions, it seems reasonable to expect that the courts would rule in favor of community corrections services, in the event that a parolee were to file suit alleging that he or she was unconstitutionally segregated or excluded from a residential facility as a result of his or her HIV antibody status. However, the expense of segregation and its ultimate utility in dealing with transmission may make such a policy untenable.

## Challenges to HIV Antibody Testing

To date, there have been no suits challenging mandatory mass screening for antibodies to HIV, although such a suit might result if HIV status became a widespread criterion for determining eligibility for parole. There have been, however, several challenges to other antibody testing situations. In Connecticut an inmate tried to prevent blind epidemiological studies of the incidence of HIV in the correctional population in the case of *Durham v. Commissioner of Corrections,*[17] but the case was dropped by the plaintiff. In an Oklahoma case, an inmate claimed that he was tested against his will,[18] emphasizing the care which must be taken to define procedures carefully before conducting any kind of testing.

Numerous suits have been filed by inmates and staff of correctional facilities seeking mandatory testing and segregation of seropositives in order to ensure protection from HIV infection; these cases may have some relevance to the issue of screening for residential placement. The courts have upheld, thus far, correctional systems' policies not to institute mass screening, and are likely to be consistent in cases involving residential facilities.[19]

### Confidentiality of Medical Information

As of yet, there have been no suits filed by clients or staff challenging the disclosure or the confidentiality of medical information regarding AIDS and HIV infection in a community corrections environment.

As has been the case with inmates in correctional facilities, probationers or parolees may challenge the disclosure of information about their HIV status. As the risks of transmission associated with confinement are not present for community corrections services, a client may well be able to invoke his or her right to privacy and build a potentially strong case against the agency and/or the officer responsible for making an unauthorized disclosure.

Additionally, a probationer or parolee could have grounds for claiming mistreatment, defamation or psychological hardship or damage as a result of the disclosure. Recent legislation suggests that an exception to such a ruling may be cases involving disclosure to spouses. For example, California has enacted laws permitting physicians to disclose a patient's HIV antibody status to his or her spouse. Should an individual refuse to inform a spouse of his or her medical condition, an agency may well have firm legal grounds for making a confidential disclosure.

On the other hand, there may be instances in which community corrections staff try to obtain lists of all seropositives within their system. Two such suits have been filed by staff of correctional facilities, one permitting and one limiting such disclosure. In Delaware, a group of inmates claiming to have had homosexual relations with an HIV-infected inmate volunteered to be tested with a guarantee of confidentiality. In response, officers filed a union grievance claiming that based on a provision of their contracts, they were entitled to know which inmates were "suspected of having any communicable disease." The court ruled that the correctional system, abiding by the terms of the contract, must disclose the names of the seropositives.[20] In Nevada, however, correctional officers have made several attempts to gain access to similar lists. The state's attorney general issued an opinion that disclosure was limited to those who "have a legitimate medical need to know in connection with the prevention and control of "AIDS."[21]

## Issues Raised by Staff: Community Corrections' Liability and Concerns

One of the most serious legal concerns for community corrections services is the threat of liability should staff, probationers or parolees, or members of the community become infected with HIV as a result of contact with an infected individual. A federal district court judge noted that, in the case of prisons, "prison officials might face a §1983 suit for failing to isolate a known AIDS patient or carrier, if the carrier infects another inmate who could show that such failure to isolate constituted grossly negligent or reckless conduct on the part of such officials."[22]

Plaintiffs alleging HIV infection as a result of negligence face two serious problems. First, with the possible exception of blood transfusions and spouse infection, it is very difficult to link a particular incident to transmission. And secondly, as community corrections systems cannot be expected to monitor the most intimate acts of their clients or to enforce behavior changes, it would be difficult to establish that an agency or officer was negligent in allowing the incident to occur.

To avoid potential liability, community corrections services should attempt to prevent high-risk behavior among clients through AIDS education and training, particularly for those at risk of infection, including homosexuals, drug users, and sex offenders. All clients who are known to have AIDS, ARC, or asymptomatic HIV infection should be counseled regarding their responsibility to inform sexual partners of their medical condition. And, as previously discussed, in the event that a client refuses to make such a disclosure, the agency should consider making a confidential disclosure in keeping with laws and/or policies of the jurisdiction.

Residential facilities, like correctional facilities, may be held liable for damages resulting from homosexual rapes and other assaults.[23] However, correctional facilities have not been held liable for insuring the *absolute* safety of persons in their custody. In several cases, the courts have ruled that a facility can only be held liable for assaults it knew or should have known would occur.[24]

Although no cases of this kind have been filed, community corrections services may also be concerned with the liability involved should an employee be infected by a probationer or parolee under his or her supervision. Systems are not mandated by law to insure the absolute safety of their employees, but are only held to a reasonable standard of care. An agency is not liable for injury incurred in the line of duty unless procedures are violated or the department is found to be otherwise negligent. While worker's compensation might well apply, negligence on the part of the agency would also have to be established in the case of HIV infection. Inadequate AIDS education and training or poor precautionary guidelines against HIV infection could be sufficient to establish such negligence. Training and procedures should be well-documented as protection against future lawsuits.

The question of whether or not an individual may be compelled to be tested for HIV antibodies following an incident in which transmission may have occurred is complex. Some jurisdictions prohibit mandatory testing and it can be argued that forced testing violates a person's Fourth Amendment protection from search and seizure. Some recent state-level legislation suggests, however, that persons involved in aggressive or negligent acts can be required to undergo testing. For example, judges may issue a court order requiring testing and disclosure in special cases. In Houston, Texas, court orders requiring testing have been issued to sex offenders.[25] In Florida, search warrants are issued for "examinations" of persons with sexually transmitted diseases, including AIDS.[26]

Notably, at least two such cases have been decided in favor of the defendant. A Massachusetts trial judge ruled that an inmate who had allegedly scratched and spit on a guard could not be required to undergo HIV antibody testing based on a state law prohibiting forced testing and disclosure as well as on medical evidence against HIV transmission through saliva.[27] Similarly, a California court revoked a search warrant authorizing HIV antibody testing of a defendant charged with biting a police officer, based on a state law prohibiting the disclosure of test results without the subject's informed consent.[28]

Staff of community corrections services express two major concerns regarding AIDS. The first is the possibility of HIV transmission in the course of their jobs, and the second is the threat of personal liability as a result of actions taken or not taken regarding clients with AIDS, ARC, or asymptomatic HIV infection.

While survey results indicate that few community corrections staff have taken concerted action regarding HIV infection on the job, correctional facilities have had complaints, particularly by those working in special AIDS units, and have received demands for "hazardous duty" pay and/or reduced working hours. These fears—and demands—can only be addressed through AIDS education and training and through written policies which outline an agency's response to incidents in which transmission may have occurred. In one case reported in the NIJ survey, staff refused to participate in urinalysis testing procedures due to fear of HIV transmission from probationers and parolees. An education and training program took place and the issue was settled. In another instance, staff took concerted action to obtain training from the agency. In a third reported case, officers attempted to pressure the parole department to release HIV status of parolees under their supervision. No full legal action was pursued.

A frightening prospect for staff is the possibility of a lawsuit filed against a community corrections officer. Should such a case be filed, 75 percent of probation and 77 percent of parole agencies surveyed report that they would provide defense for the officer who acted within the line of duty; a few others would provide defense in all circumstances. Some systems (44 percent of probation and 35 percent of parole) have liability insurance to cover officers who are sued. Forms of coverage include state indemnification statutes, comprehensive general liability, or state insurance funds for risk management. In a limited number of jurisdictions, self-insurance is also available.

In most cases an officer's concerns can be alleviated through written policies which describe how agencies will respond to a lawsuit. Few agencies have state or local guidelines explaining potential criminal or civil liabilities. However, 44 percent of probation systems surveyed and 36 percent of the parole systems surveyed disseminate information to agency staff concerning general representation and damages.

## Obligation to Perform Duties

Survey results indicate that only three probation systems and one parole system have faced potential work disruptions as a result of staff members who have refused to work with HIV-infected clients. In general, agencies have taken the position that fear of AIDS does not excuse employees from performing duties, as there is a very low risk of HIV infection associated with occupational activities. In response to the San Francisco Sheriff's Department request for a legal opinion as to whether officers were required to render CPR to inmates known or suspected to be HIV-infected, the city attorney's office asserted that deputies have an unequivocal responsibility to provide CPR whenever necessary, as failure to do so could make the city liable for any resulting injury and subject the employee to disciplinary action.[29]

Pregnant staffers, however, are an exception to this rule. In California, for instance, no pregnant women may be assigned duties involving the supervision or care of persons with AIDS. This is because of the risk of exposure to cytomegalovirus (CMV), commonly found in persons with AIDS, which can cause birth defects.

Precise and accurate AIDS education and training, coupled with policies calling for swift disciplinary action should an employee refuse to perform his or her duties out of fear of AIDS, can effectively allay most concerns and disruptions among community corrections staff. Legally, an employee cannot refuse work in other situations because of personal bias, such as work with a handicapped, female, or minority co-worker. Though not tested in the courts, the rulings may hold true for refusal to work with a co-worker or client with AIDS.

### Policy Recommendations

In this chapter we have reviewed some of the legal issues involved in dealing with AIDS in community corrections. In the following sections, we summarize some of the key questions and answers.

- ***What are the legal guidelines for disclosing the HIV status of someone under supervision to third parties such as spouses, other family members, potential residential placements or employers?***

  Each state has different laws regarding confidentiality of HIV status information. Many states require mandatory reporting to Public Health Departments by medical personnel identifying the condition; this does not include reporting by or to community corrections services. Community supervision staff should seek legal verification of the confidentiality and disclosure statutes in their state before any disclosure or special placement is made. For example, in most states staff may not disapprove a client's residence plan if he or she refuses to disclose HIV status to the person with whom he or she will be living. Such a disapproval could be seen as a violation of the right to confidentiality.

- ***Can staff refuse to supervise or work with HIV-infected persons?***

  No. Refusal to work with AIDS-infected persons could be interpreted as discrimination if the infected individual is otherwise carrying out his or her obligations, either job obligations or the requirement to report for supervision. Only in the case of a pregnant supervisory officer might this refusal be allowable.

- ***What is the best protection against third-party suits in community corrections?***

  Suits can be mounted against corrections staff on grounds such as inappropriate disclosure of HIV status, failure to disclose with resultant third-party injury, or damages due to inadequate medical management resulting in injury. Detailed disclosure guidelines for protection of confidentiality and documented training in those guidelines provide the best protection in these instances. Similarly, the problems of inadequate medical management can be alleviated by training of staff in AIDS information and referral systems available. Failure to disclose, while troubling to many supervisory staff, is a problem generally dealt with by restrictions of state and federal law.

- ***Can I require testing for an individual whom I suspect is HIV antibody-positive and who is involved in a transmission incident?***

This depends on your state's laws. Some agencies currently can obtain a court order in cases of transmission incidents which can be used to force HIV antibody testing. Careful examination of the incident is urged prior to such action. For example, is it an incident in which a real risk exists, as in a rape, or a negligible or non-existent risk, as in a biting or spitting incident? It may be more prudent to have the victim tested for a six-month period than to avoid possible legal action from the offender.

- ***Can state residential placement facilities refuse to house HIV antibody-positive parolees?***

Again, depending on state law, this may be legally possible. Case law nationally has upheld segregation of persons with AIDS in prisons and jails. A more cautious approach, however, argues that all individuals be treated as though seropositive since there is no way to determine the HIV status over time of the total population. Persons deemed acceptable at one point in time are possibly unacceptable (infected) at later points. These realities should be stressed to residential facilities, few of which have resources available for repeated testing of residents.

## NOTES

1. *AIDS Policy Guidelines for Probation Departments and Alternatives Programs*, State of New York Division of Probation and Correctional Alternatives, Albany, New York, 1987, p. 3.
2. *AIDS Information Guide*, New York State Parole Operations, Albany, New York, April 1986, p. II-3.
3. *Ibid*., p. III-11.
4. Colorado: H.B. 1177, Chapter 208, 1987 Laws.
5. D. Chamlee, Chief of the Federal Division of Probation, letter to Benjamin F. Baer, chief of the U.S. Parole Commission, September 29, 1987.
6. *AIDS Policy Guidelines*, Section 410.90 of the New York State Criminal Procedure Law; p. 16.
7. *School Board of Nassau County v. Arline*, 107 S. Ct. 1123 (1987).
8. D.W. Kmiec, Office of Legal Counsel, U.S. Department of Justice, Memorandum, October 6, 1988.
9. *School Board of Nassau County, op. cit.*
10. Kmiec, *op. cit.*
11. *Doe v. Charlotte Memorial Hospital*, Complaint No. 04-84-3096 (August 5, 1986); *Thomas v. Atacadero Unified School District*, Civil No. 86-6609, U.S. Dist. Ct. (C.D. California, November 7, 1986); *Shuttleworth v. Broward County*, 639 F. Supp. 654 (S.D. Florida, 1986); *American Federation of Government Employees Local 1812 v. U.S. Department of State*, 25 Govt. Empl. Rel. Reptr. (BNA) 612 (U.S.D.C. D.C. No. 87-0121, April, 22, 1987).
12. Chamlee, *op. cit.*
13. 607 F Supp 9 (S.D.N.Y., 1984).
14. U.S.D.C., N.D. Oklahoma, Nos. 85-C-820-C and 85-C-816-B, dismissed February 20, 1986.
15. U.S.D.C. -N.D. Alabama, No. CV-86-HM-5592-NE. Decided April 20, 1987.
16. *Farmer v. Levine* (U.S.D.C. -Maryland, 1985), No. HM-85-4284, 19. Magistrates Report dated May 28, 1986; *Marioneaux v. Colorado State Penitentiary*, 465 F Supp. 1245 (1979); *Johnson v. Fair* (U.S.D.C. - D. Massachusetts, 1987). Civil Action NO. 87-0217 Mc; *Williams v. Sumner* 648 F. Supp. 510 (C.D. Nevada, 1986) *Doe v. Coughlin* 509 NYS 2d 209 (NY App. 1986). Buraff Publications, *AIDS Policy and Law*, December 2, 1987, 2:5.
17. Hartford District Court, Civil No. H-87-623.
18. *Dunn v. White* (U.S.D.C. - N.D. Oklahoma) No. 87-C-753-C.
19. For some examples see *Wiedmon v. Rogers* (U.S.D.C., E.D., North Carolina), No. C-85-116-G; *Maberry v. Martin* (U.S.D.C., E.D., North Carolina), No. 86-341-CRT; *Potter v. Wainwright* (U.S.D.C., Middle Dist. Florida), No. 85-1616-CIV-T15; *Stalling v. Cave* (2d Circuit, De Leon County); *McCallum v. Staggers* (5th Circuit, Lake County), No. 85-1338-CAOI; *Bailey v. Wainwright* (8th Circuit, Baker County); *Lloyd v. Wainwright* (2d Circuit, De Leon County), No. 86-3144; *Jarrett v. Faulkner*, (U.S.D.C. S.D. Indiana), No. IP85-1569-C; *Herring v. Keeney* (U.S.D.C., Oregon), filed September 17, 1985, decided July 1987; *Piatt v. Ricketts* (U.S.D.C., Arizona), No. CIV-85-538-PHX); *Foy v. Owens* (U.S.D.C., E.D. - Pennsylvania, 1986), Civil Action No. 85-6909; *Lareau v. Manson* 651 F. 2d 96 (2d Cir. 1981); *Bell v. Wolfish* 441 U.S. 520 (1979); *Estelle v. Gamble* 429 U.S. 97 (1976).
20. *State Department of Correction v. Public Employees Council 82* (Del h. 1987), Civil Action No. 8462.
21. *AIDS Policy and Law*, December 16, 1987; 2:5; *Carson City Nevada Appeal*, November 12, 1987, p. A-10.
22. *Judd v. Packard*, (unreported opinion, U.S.C. D. -Maryland), Civil Action No. S 87-1514, September 24, 1987. Cites *Withers v. Levine* 625 F. 2d 158 (4th Cir.), cert denied, 449 U.S. 849 (1980).
23. See *Redmond v. Baxley* 475 F. Supp. 1111 (U.S. D. C. E. Dist. Mich. 1979); *Garrett v. United States* 501 F. Supp. 337 (U.S.D.C., N. Dist. Georgia 1980); *Saunders v. Chatham County* 728 F. 2d 1367 (11th Cir. 1982); *Kemp v. Waldron* 479 N.Y.S. 2d 440 (Sup. Ct. 1984); *Thomas v. Booker* 762 F. 2d 654 (8th Cir. 1985).

24. See *Mosby v. Mabry* 699 F. 2d 213 (8th Cir. 1982); *O'Quinn v. Manuel* 767 F. 2d 174 (5th Cir. 1985).

25. *Manual of Policies and Procedures for Health Services*, No. 3-39, October 1987, p. 6.

26. §796.08 Florida Statutes (Supplement 1986). See Aylesworth, G. and Knabe, R., "Warrant for Examination for Sexually Transmitted Diseases," *Florida Police Chief*, December 1987, 13:63.

27. *Dean v. Bowie*, Suffolk Sup. Ct. (Massachusetts), Civil Action #87-4745.

28. *Barlow v. Superior Court* 236 Cal Rptr. 134 (Cal. App. 4th Dist. 1987).

29. "Deputy Sheriff's Duty to Administer CPR," City Attorney George Agnost to Sheriff Michael Hennessey, July 1, 1985.

# Chapter 6: GENERAL POLICY GUIDELINES ON AIDS FOR PROBATION AND PAROLE SERVICES

The development of a policy response to AIDS in community corrections requires the incorporation of information from all of the areas discussed in this volume. What constitutes an AIDS policy—in terms of both content and comprehensiveness—varies widely from state to state, and even within counties of the same state. For the federal parole and probation systems, AIDS policy is covered under the guidelines included in Appendix F. These guidelines, discussed below, follow CDC guidelines and recommendations and are meant to provide general guidance for federal parole and probation systems. Many states have begun to use the same process in developing policy—looking to the federal system or to public health sources for guidance and adopting general position statements on AIDS.

Other AIDS policy packages are far more developed and specific. Some include comprehensive steps for disseminating information and making referrals, such as the New York State Parole Guidelines. Others, such as Georgia's, provide specific conditions of parole and instructions for officers. This chapter reviews state and federal efforts in AIDS policy development for community corrections and summarizes AIDS policy suggestions arising from this study. General AIDS policy statements and guidelines are addressed. Specific suggestions in the areas of education, legal issues, and testing can be found in each of the previous chapters.

It should be emphasized that no single policy is appropriate for all jurisdictions. However, it is hoped that this document will aid in the development of a sound policy, tailored to the needs of each area. We begin with a discussion of three policy statements issued by three groups—the American Parole and Probation Association (APPA), the Federal Division of Probation, and the U.S. Parole Commission.

## American Probation and Parole Association

At the August 1988 meeting of the APPA Board of Directors the "American Parole and Probation Position Statement on AIDS" (Figure 6.1) was adopted. This statement stresses the importance of local agency development of policies and/or procedures regarding AIDS training, precautionary measures, and confidentiality protection for use in community corrections settings. Written as a single-page, general statement, the APPA document recommends that all offenders receive AIDS information. In addition, it recommends special attention be given to IV drug abusers and others exhibiting high-risk behavior. It encourages information and presentation of testing options as part of an education effort both for staff and for probationers and parolees.

With respect to disclosure of clients' HIV status, the APPA suggests that inappropriate disclosure of an individual's status to any third party is a "violation of his/her right to privacy." However, in cases in which individuals are continuing high-risk behaviors and endangering known third parties, correctional staff are urged to seek legal and supervisory assistance in determining whether or not to disclose the clients' HIV status.

Finally, the policy emphasizes that probation and parole officers are never exposed to situations where transmission of the AIDS virus is likely in the routine daily performance of their duties and should not consider HIV-infected clients a threat to their own safety.

In summary, the APPA statement emphasizes that:

- AIDS education and training for all staff and clients is important and particularly critical in the case of drug-using offenders.
- Confidentiality procedures must be strictly followed and may be breached only after legal consultation and in the face of imminent threat to a third party.
- Community corrections officers are not at risk of contracting the AIDS virus in carrying out routine duties, if they follow standard hygienic procedures.

## Federal Division of Probation and the U.S. Parole Commission

Both the U.S. Parole Commission and the Federal Division of Probation have developed guidelines for the management and supervision of HIV antibody-positive probationers and parolees. Both sets of guidelines can be found in Appendix F.

Figure 6.1

# AMERICAN PROBATION AND PAROLE ASSOCIATION POSITION STATEMENT ON AIDS

## Introduction

Acquired Immune Deficiency Syndrome (AIDS) has emerged as a significant concern and challenge to correctional administrators. As the numbers of HIV positives, persons with ARC, and persons with AIDS continue to multiply, probation and parole personnel must be aware of the implications of various actions and non-actions, confidentiality issues, and medical facts. Policies and procedures governing all facets of AIDS prevention and education must reflect best current medical and ethical practices.

## Discussion

The American Probation and Parole Association supports the findings and recommendations of the National Institute of Justice in "AIDS and the Law Enforcement Officer" and "AIDS in Correctional Facilities." While neither of these publications specifically addresses the unique issues faced by probation and parole officers, the detailed analysis assesses many of the major areas of concern expressed by staff.

Education of all citizens about the dangers and means of transmission of the human immunodeficiency virus is a primary social objective. Offenders demonstrating high risk behaviors should be targeted for intensive educational efforts. Drug-abusers, in particular, should receive special attention and services. Other offenders should also be provided with information about preventive measures and testing options.

Disclosure of offender medical information presents difficult ethical, legal and professional dilemmas. As a general rule, such information is confidential. When staff become aware that a specific offender is HIV-positive, disclosure to other parties without the subject's informed consent is a violation of his/her right to privacy. In special cases where there is evidence suggesting on-going high-risk behavior that might result in the infection of a third party, the right to privacy may be outweighed by a duty to warn possible victims. In such cases, staff should be encouraged to seek supervisory and legal assistance on a case by case basis.

In the daily performance of their duties, probation and parole officers are rarely exposed to situations where viral transmission is possible. The only recognized means of contracting the AIDS virus is through blood to blood contact or seman to blood contact. Neither is likely to occur in the context of the probation/parole officer's job. Common hygienic procedures and recognition of high-risk behaviors and situations should be sufficient to prevent exposure. Officers may wish to carry rubber or surgical protective wear. The AIDS virus is not easily transmitted, and there is no evidence that professionals employed in law enforcement fields are at risk of contracting it, if standard procedures are followed.

## Position

All jurisdictions should develop policies and procedures which stress regular training, utilizing the latest medical research; provision of appropriate safety and hygenic materials, equipment, and information; consideration of prevailing confidentiality statutes; and opportunities for staff to discuss issues of concern.

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*Final adoption of this position statement will take place at the August 28, 1988 meeting of the APPA Board of Directors. For further information contact: Mr. Ben Jones, APPA, P.O. Box 11910, Lexington, KY 40579, (606) 252-2291.*

A statement made during testimony by the U.S. Parole Commission Chairman, Benjamin F. Baer, summarizes the current position of his agency:

> ". . . the Commission does not view itself, under its statute, as having the power to take action directed solely to protecting the public from the spread of AIDS, at least to the extent that activity which would spread AIDS is not also criminal activity."[1]

Guidelines for federal probation officers developed by the Judicial Conference Committee on Criminal Law and the Probation Administration for use by federal probation officers and pre-trial service officers outline recommended steps for managing persons who have been exposed to HIV or who have developed symptomatic AIDS infection (see Appendix F). These guidelines suggest that an individual case plan be developed for the offender in cooperation with a resource person within the agency who is specially designated and trained for dealing with HIV infection.

## Education and Training

Both federal policies stress the importance of AIDS education, counseling, and treatment in the offender's re-entry into the community. However, federal policy for both probation and parole systems also stresses that the HIV infected offender should not be treated differently than others under supervision unless their medical condition requires special considerations. Similar to the APPA guidelines, both the federal parole and probation systems recommend that educational materials be made available to probationers. In addition, they recommend that specially designated officers be trained in AIDS information and referrals and serve as an AIDS resource officer. This officer should be particularly well versed in the state's confidentiality laws. The Parole Commission also recommends AIDS information/education for all parolees. In the case of parole, this programming in such programs could be made a condition of release for persons known to be infected or at risk. It can be argued that participation in such programming is both enforceable and in keeping with the mission of community corrections. Unlike monitoring private behaviors, monitoring actual participation in classes or treatment session could be accomplished by correctional staff.

### *Policy for disclosure to third parties.*

**Federal probation.** Disclosure of HIV status to sexual or drug partners remains with the individual supervised in the federal probation system, though supervisors are instructed to impress upon him or her the importance of self-disclosure and the possible criminal liabilities of non-disclosure to sexual/drug partners. As is true in states with strict disclosure regulations, the federal probation system requires informed, written consent of the supervisee before officers may disclose to family members, parents, or sexual/drug partners, if the supervisee refuses to disclose. The exception to this is, in those states which permit non-consensual disclosure to public health officials.

Therefore, officers are instructed to disclose the HIV status of probationers only when informed written consent is obtained; in states which permit disclosure to public health officials, officers may disclose to this source, drawing on the ability of public health officials to further encourage the person to disclose his/her status to sexual/drug partners.

The case of disclosure to criminal justice officials, residential placement facilities, halfway houses, and jails is somewhat different. Probation officers are instructed to attempt to have the supervisee give his/her informed, written consent to release HIV status information to these sources. However, if he/she refuses to do so, they advise that this information be released to the U.S. Marshall when a warrant for violation of conditions of his/her release is issued and to the health care officials of a residential placement or jail facility when the person is put into its custody.

**Federal parole.** The U.S. Parole Commission position states that it is appropriate to make a "discrete and confidential warning" to third parties in certain cases, after consultation with public health officials. In such cases, 1) the parolee is known to be infected; 2) a clear risk to a third party exists; 3) public health officials have been unsuccessful or unwilling to make a warning; and 4) state law does not prohibit such disclosure. Moreover, the Parole Commission recommends that if a violator warrant is issued for an HIV-infected individual, the U.S. Marshal should be notified.[2] It is important to note that all staff are urged to gain permission from the parolee and, if permission is denied, only act within the individual state's laws.

Both Federal agencies recommend that supervisory officers consult with public health authorities in their local areas to determine if disclosure to public health agencies is allowed under the laws of their state before any form of disclosure, even to those same public health officials. Both agencies also stress the need for confidential record keeping. Both supervisory staff are directed only to disclose to designated public health officials as allowed by state law; in addition, they are encouraged, if possible, to get written voluntary consent from the infected person to protect themselves fully from problems related to unauthorized disclosure.

## Maintenance of Records

**Federal probation.** Information about a probationer's HIV status may be unofficially disclosed or available to supervisors from a variety of sources – case records, third parties, etc. Before any further disclosure of this information, probation supervisors are instructed to get their written authorization of the probationer, including specific persons to whom the information can be released, i.e., sexual partners, medical services, drug treatment providers. In addition, they are instructed that all information related to the probationers HIV status should be kept in a separate section of his/her case record marked as confidential information. Probation guidelines recommend that persons within the criminal justice agency who have this information should be limited to only those with direct supervisory responsibilities. This means that such information should not be included in pre-trial service or presentence investigation reports unless it is related to the offense, such as in the case of sexual assault. However, courts may order complete disclosure of such information. In this case, the probation division recommends the officer provide it in confidence and with it state the defendant's refusal to give consent for disclosure.

**Federal parole.** The Federal Bureau of Prisons instituted testing of all inmates prior to release from federal prisons in June of 1987. Thus, the HIV status of new parolees may be known to federal parole officers in some instances. It should be stressed that testing at release only gives the HIV status of the individual at that time and cannot determine that he or she has not been exposed, nor predict that he or she will not, post-test, engage in risky behaviors and acquire the virus. However, protection of the confidentiality of test results is of paramount importance, and written procedures to insure that protection should be part of supervisor training.

## State level efforts: NIJ Survey Results

Among the parole and probation agencies surveyed, few have written, formal policies regarding the management of clients with AIDS. For example, over 80 percent of the state or county parole systems report no formal AIDS policy. Many, however, are in the process of developing policies or statements and were interested in the existence of policies from other jurisdictions. Some areas report that their guidelines are developing piecemeal. For example, some states may distribute information on precautionary procedures to community corrections officers as part of education and training or may copy state law on disclosure of HIV status information for distribution to officers, but do not assemble the material into a policy statement or official set of guidelines. In states with county or regional administration systems, it is possible to find one county with detailed instructions for officers and a neighboring one with no guidelines or even written educational materials available.

Policies and guidelines vary considerably in terms of what they include. In some cases a policy covers everything from general education and training to disclosure procedures. In others, it is a brief statement or agreement of purpose. It is clear, however, that the policy decisions about AIDS in community corrections are interrelated. Education and training of staff, for example, is related directly to policies regarding precautions and legal issues about on-the-job infection. States in which there are large numbers of cases and/or large numbers of IV drug users are most concerned about placement, costs, and supervision of the AIDS-infected probationer or parolee. Areas in which there are only a handful of cases tend to focus on transmission into the community at large or educating staff and the community to avoid undue fears.

## Specific restrictions policies

Policies in which conditions of release or behaviors in the community are stipulated are the most specifically restrictive policies; that is, they limit the movement or behavior of the individual in some way because of his or her HIV status. The policy of the ***Georgia*** State Board of Pardons and Parole is an example of the restrictive approach. The Georgia policy has been in effect since 1986 and is being used as a model for consideration in many states. A copy of the Georgia policy and forms can be found in Appendix G.

As of July 1988, Georgia Law requires that all inmates entering the prison system must be tested for the HIV antibody and by the year 1991, every inmate in the State correctional system will have been HIV tested. Prior to this time, testing was only conducted on inmates who exhibited symptoms of the disease or who requested to be tested. Also effective July 1988, Georgia Law authorizes the Georgia Board of Pardons and Paroles to order HIV testing of any inmate eligible for Parole. The Board has exercised this authority selectively for those whose medical profile or high-risk activities indicate a real possibly of infection. It is the Board's policy not to discriminate against those who are HIV positive, therefore all eligible inmates are considered for parole. However, the Board does require that an HIV infected person demonstrate the following prior to release:

- an awareness of the nature of HIV infection and its modes of transmission;

- a sincere commitment to prevent transmission to others;
- a supervisory plan in accordance with the above goals;
- a personal history indicating the feasibility of these goals.

The Board will not grant parole to HIV seropositive persons failing to meet these conditions, and it reserves the right to revoke parole if there is evidence of violation of the conditions of release related to AIDS. HIV-infected inmates are interviewed prior to parole consideration to determine the level of risk they present to the community.

The Board imposes several special conditions of release which it feels are "promotive of the well being of the HIV-infected individual, his family or co-residents and the general public."[3] These conditions, which the parolee must sign prior to release, include permission for the agency to disclose HIV status to the head of the household with whom he or she resides; proof of a level of knowledge about AIDS, agreement to undergo regular medical exams, promise not to engage in unsafe sexual activities or to donate blood, cooperation with public health officials, restraint of excessive use of alcohol and any use of illegal drugs, and restraint from tattooing. It is not required that the HIV-infected person disclose his or her status to an employer or prospective employer except in the instance where "the nature of the employment is such as to pose a real and immediate potential for injury to the person of the HIV-infected individual. Ordinarily, it will be deemed inappropriate for HIV-infected individuals to seek employment in a high-risk industrial position."[4]

The parolee must also sign authorization for use of any medical information by "the State Board of Pardons and Paroles for all purposes necessary to confirm the health status of the undersigned (releasee), the employment capabilities and status of the undersigned, and the compliance of the undersigned with the terms and conditions of the parole . . ."[5] This authorization serves as written consent for disclosure to spouses or sexual partners should the parolee fail to or refuse to disclose.

Disclosure of HIV status under Georgia's policy is limited to the supervising officer, persons providing medical services to the parolee, and the head of the household in which the parolee resides. Officers are trained in the importance of confidentiality of records and specific guidelines have been established to prevent unauthorized disclosure.

Under this policy, the Board of Parole is informed of any violation of these conditions and may "act to promote the health of the general public," which may include revocation of parole. It is the duty of the supervising officer to monitor closely, as well as possible, the behaviors of the parolee. During the first three months of 1988, 25 HIV-infected parolees were supervised and, of that number, three paroles were revoked for violations covered in this policy.[6]

The Georgia Board of Pardons and Paroles is utilizing a two prong approach to halting the transmission of the virus by persons on parole. On the one hand, the Special Conditions are designed to prohibit, under the threat of negative sanctions, illegal or unsafe activities. Simultaneously, the Board is providing training to every field officer in the areas of supportive counseling, treatment resources (alcohol, drug and medical), and education.

The Board believes that combining its authority to prohibit dangerous activities with a humane. compassionate and educational treatment program is the most effective way to promote the welfare of the infected parolee and the citizenry of Georgia.

Advocates of a restrictive system such as Georgia's argue that identification of releasees is essential for public safety and the safety of the releasee. By making AIDS knowledge and adherence to risk-reduction behaviors conditions of parole, they believe the justice system is actively participating in reducing transmission of AIDS. By identifying releasees who are seropositive and handling them differently, they contend the system is providing potentially better medical surveillance of their illness.

There is a great deal of debate in the correctional field about the use of restrictive policies such as this. Critics argue that, as the Federal Probation Division and the U.S. Parole Commission suggest, HIV infection is a public health issue and not the appropriate domain of the criminal justice system. In addition, they argue that HIV infection is not a static condition; repeated testing and monitoring are necessary if a policy is to have any impact on transmission of the virus. They also suggest that monitoring of private sexual behaviors of releasees is not only impossible but also an inappropriate invasion of their privacy. Finally, it has been suggested that the constitutionality of such a policy may be questionable, in that a condition of release is linked to noncriminal behaviors, and similar prohibitions are not used in the case of other communicable diseases.

## Less Restrictive Policies

The *New York State* Division of Parole began developing policy and procedural guidelines early in the AIDS crisis. It has compiled some of the most detailed and sophisticated materials for use by correctional officers to date, some of which are appended to this document.

The New York State Division of Parole produces an "AIDS Information Guide" for correctional officers, which includes general information about AIDS, policy guidelines, service and resource information and questions and answers about AIDS. In New York, there are no conditions of parole linked to HIV status. Persons whose HIV status is known have that information included in their medical discharge summaries where it may be considered by the parole board or judge. However, special treatment, such as less frequent reporting or elimination of appearances in court, are only deemed acceptable when the individual has AIDS or ARC and is seriously ill or incapacitated by the disease. Persons with AIDS may not automatically be reclassified for reduced reporting in New York State, but must go through reclassification for medical reasons, as would any other individual who is ill and unable to report. However, those with AIDS or ARC are not required to make an Arrival Report to their local office upon release, but may instead telephone in their report.

Parole officers may not disclose AIDS diagnosis or HIV status without the written consent of the parolee. Officers are strongly advised to gain consent for release of information from the parolee even in medical or social service referrals. Similarly, in the New York State probation system, the probationer's HIV status may appear in a medical evaluation portion of the presentence investigation, but access to that information is limited to parties specified by law. Probation officers are asked to encourage vigorously that clients disclose their status to sexual partners. It is stressed, however, that without client consent, the officer may not disclose the information.

There is no mandatory testing in New York State, nor is there routine testing for persons engaging in high-risk behaviors in either parole or probation services. For those probationers or parolees who are known to be positive (either from prior medical records, presentence investigation reports, diagnosis of current illness, or from voluntary report of their status), New York State community corrections services provide a broad range of referral services. These services are listed in the guides developed for officers' use.

Probation Services of the Administrative Office of the Courts in ***New Jersey*** has formulated through its Intensive Supervision Program a policy for dealing with HIV infection and AIDS in probationers. It includes specific protocols for dealing with those with AIDS or ARC, including recommendations for voluntary testing and the development of case-management plans. It advises that face-to-face contact with the probationer is to be continued unless illness renders this impossible. Any modification of contact procedures must be made formally. IV drug users with AIDS or ARC who continue to use drugs (as evidenced in regular urine screens) are considered in violation of probation conditions to prevent transmission through needle sharing.

New Jersey does not recommend general HIV screening for probationers and parolees. Instead, it advises officers to urge HIV testing for persons exhibiting symptoms of illness or involved in high-risk behaviors. There are no special residential placements or conditions of release directly related to AIDS. It is also advised that a general medical examination be conducted for these individuals. New Jersey also provides a guide to services in regions of the state for use by supervising officers.

## Elements of a good AIDS Policy and Procedural Guide

Summarized below are the basic elements of a comprehensive policy or set of guidelines for dealing with HIV infection and AIDS in community corrections. These elements may be incorporated into a simple statement to be used as a guide for programming. Alternatively, they may be presented in a more elaborate training manual or notebook format. Guidelines presented as frequently updated notebooks with separate sections on issues, questions and answers, and resource guides are the most complete. Key elements include:

- Detailed statement of the confidentiality and disclosure laws of your state with specific questions and answers for practitioners;
- Detailed written confidentiality procedures for all records containing HIV status information;
- Program outlining mandatory education and training for staff and clients about AIDS, its transmission, and risk-reduction behaviors;
- Detailed steps for officers to follow with a person whose positive HIV status is known to them, i.e., what to do about placements, reporting agendas;
- Detailed list of resources and how to use them for persons with AIDS or HIV infection;
- Statement about state's policy and rationale for any HIV antibody testing, i.e., when it is deemed appropriate and legal, under what circumstances it should be suggested;
- Universal precautionary measures; and
- Legal and labor relations issues for employees with AIDS or HIV infection.

# CONCLUSION

AIDS has presented society with a serious dilemma. While it is essential to be supportive and helpful to persons who have contracted this infection, the fatal nature of the illness can frighten the most humane and reasonable people. The difficulties society faces with this issue are even more acute in community corrections, where a disproportionate number of persons in need of supervision may be infected with the virus.

The response to this crisis has been growing in community corrections across the country. Many areas have begun with important education and training of staff to serve better the infected or ill probationer or parolee and the community. This is a critical first step in dealing with misinformation and fears surrounding this disease. In many of the materials received in the development of this document, and in many conversations with community corrections administrators, it was often repeated that a situation of fear and apprehension among staff and clients was noticeably reduced after the institution of an education program. In addition, some areas have developed invaluable resource guides to help supervisory staff in directing clients to appropriate medical and social services for dealing with AIDS.

The most critical need is for detailed informational support and specific procedural guidelines for parole and probation officers on how to handle the day-to-day issues the AIDS-infected client presents. Some jurisdictions, such as New York, have done admirable jobs in this regard. Others need to follow this lead with material tailored to the statutes and conditions of their areas. While general statements of purpose—such as the protocol included in Appendix H—are important as guiding principles for agencies and officers to follow, the need for step-by-step guidelines and case management suggestions is critical.

## NOTES

1. "House Panel Hears Corrections, Parole Officials Discuss AIDS Policies for Prisoners, Parolees," *The Third Branch: Bulletin of the Federal Courts*, December, 1987, 19 (12): 7-8.
2. *Parole Commission Instructions to Probation Officers*, U.S. Parole Commission, 1987.
3. "Policy for the Human Immunodeficiency Virus Infected": Georgia.
4. *Ibid.*
5. "Special Conditions of Parole for HIV-Infected Parolees": Georgia.
6. "New Georgia law to permit tests of would-be parolees," *AIDS Policy and the Law*, April 20, 1988, Vol. 3 (1): 9-10.

# APPENDICES

# APPENDIX A

## Probation and Parole Divisions/Agencies Responding to NIJ Survey on AIDS Issues

# STATES WITH PROBATION DIVISIONS/AGENCIES RESPONDING TO NIJ SURVEY ON AIDS ISSUES

Where counties are listed, these were the respondents; if only the state is listed, then the central agency responded.

1. ALABAMA
2. ALASKA
3. ARIZONA
   - Maricopa
   - Pima
4. ARKANSAS
5. CALIFORNIA
   - Contra Costa
   - Fresno
   - Los Angeles
   - Orange
   - Sacramento
   - San Diego
   - San Mateo
   - Sonoma
   - Sutter
6. COLORADO
7. CONNECTICUT
8. DELAWARE
9. FLORIDA
10. GEORGIA
11. HAWAII
12. IDAHO
13. ILLINOIS
    - Cook
14. INDIANA
15. IOWA
16. KANSAS
17. KENTUCKY
18. LOUISIANA
19. MAINE
20. MARYLAND
21. MASSACHUSETTS
22. MICHIGAN
23. MINNESOTA
24. MISSISSIPPI
25. MISSOURI
26. MONTANA
27. NEBRASKA
28. NEVADA
29. NEW HAMPSHIRE
30. NEW JERSEY
31. NEW MEXICO
32. NEW YORK
    - Erie
    - Monroe
    - Nassau
    - New York City
    - Suffolk
    - Westchester
33. NORTH CAROLINA
34. NORTH DAKOTA
35. OHIO
36. OKLAHOMA
37. OREGON
    - Marion
38. PENNSYLVANIA
    - Allegheny
    - Blair
    - Chester
    - Lackawanna
    - Lehigh
    - Lycoming
    - Westmoreland
39. RHODE ISLAND
40. TENNESSEE
41. TEXAS
42. UTAH
43. VERMONT
44. VIRGINIA
45. WASHINGTON
46. WEST VIRGINIA
47. WISCONSIN
48. WYOMING

# STATES WITH PAROLE DIVISIONS/AGENCIES RESPONDING TO NIJ SURVEY ON AIDS ISSUES

Where counties are listed, these were the respondents; if only the state is listed, then the central agency responded.

1. ALABAMA
2. ALASKA
3. ARIZONA
4. ARKANSAS
5. CALIFORNIA
6. COLORADO
7 CONNECTICUT
8. DELAWARE
9. FLORIDA
10. GEORGIA
11. HAWAII
12. IDAHO
13. INDIANA
14. IOWA
15. KANSAS
16. KENTUCKY
17. LOUISIANA
18. MAINE
19. MARYLAND
20. MASSACHUSETTS
21. MICHIGAN
    Wayne
22. MINNESOTA
23. MISSISSIPPI
24. MISSOURI
25. MONTANA
26. NEBRASKA
27. NEVADA
28. NEW HAMPSHIRE
29. NEW MEXICO
30. NEW YORK
31. NORTH CAROLINA
32. NORTH DAKOTA
33. OHIO
35. OREGON
    Marion
36. PENNSYLVANIA
37. RHODE ISLAND
38. SOUTH DAKOTA
39. TENNESSEE
40. TEXAS
41. UTAH
42. VERMONT
43. VIRGINIA
44. WASHINGTON
45. WEST VIRGINIA
46. WISCONSIN
47. WYOMING

# APPENDIX B

## Medical Definitions

- *Centers for Disease Control (CDC) Definition of AIDS*
- *National Institutes of Health (NIH) Definition of ARC*

Reprinted by the
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
CENTERS FOR DISEASE CONTROL

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# Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome

*Reported by*
*Council of State and Territorial Epidemiologists;*
*AIDS Program, Center for Infectious Diseases, CDC*

## INTRODUCTION

The following revised case definition for surveillance of acquired immunodeficiency syndrome (AIDS) was developed by CDC in collaboration with public health and clinical specialists. The Council of State and Territorial Epidemiologists (CSTE) has officially recommended adoption of the revised definition for national reporting of AIDS. The objectives of the revision are a) to track more effectively the severe disabling morbidity associated with infection with human immunodeficiency virus (HIV) (including HIV-1 and HIV-2); b) to simplify reporting of AIDS cases; c) to increase the sensitivity and specificity of the definition through greater diagnostic application of laboratory evidence for HIV infection; and d) to be consistent with current diagnostic practice, which in some cases includes presumptive, i.e., without confirmatory laboratory evidence, diagnosis of AIDS-indicative diseases (e.g., *Pneumocystis carinii* pneumonia, Kaposi's sarcoma).

The definition is organized into three sections that depend on the status of laboratory evidence of HIV infection (e.g., HIV antibody) (Figure 1). The major proposed changes apply to patients with laboratory evidence for HIV infection: a) inclusion of HIV encephalopathy, HIV wasting syndrome, and a broader range of specific AIDS-indicative diseases (Section II.A); b) inclusion of AIDS patients whose indicator diseases are diagnosed presumptively (Section II.B); and c) elimination of exclusions due to other causes of immunodeficiency (Section I.A).

Application of the definition for children differs from that for adults in two ways. First, multiple or recurrent serious bacterial infections and lymphoid interstitial pneumonia/pulmonary lymphoid hyperplasia are accepted as indicative of AIDS among children but not among adults. Second, for children<15 months of age whose mothers are thought to have had HIV infection during the child's perinatal period, the laboratory criteria for HIV infection are more stringent, since the presence of HIV antibody in the child is, by itself, insufficient evidence for HIV infection because of the persistence of passively acquired maternal antibodies < 15 months after birth.

The new definition is effective immediately. State and local health departments are requested to apply the new definition henceforth to patients reported to them. The initiation of the actual reporting of cases that meet the new definition is targeted for September 1, 1987, when modified computer software and report forms should be in place to accommodate the changes. CSTE has recommended retrospective application of the revised definition to patients already reported to health departments. The new definition follows:

# 1987 REVISION OF CASE DEFINITION FOR AIDS FOR SURVEILLANCE PURPOSES

For national reporting, a case of AIDS is defined as an illness characterized by one or more of the following "indicator" diseases, depending on the status of laboratory evidence of HIV infection, as shown below.

## I. Without Laboratory Evidence Regarding HIV Infection

If laboratory tests for HIV were not performed or gave inconclusive results (*See* Appendix I) and the patient had no other cause of immunodeficiency listed in Section I.A below, then any disease listed in Section I.B indicates AIDS if it was diagnosed by a definitive method (*See* Appendix II).

A. **Causes of immunodeficiency that disqualify diseases as indicators of AIDS in the absence of laboratory evidence for HIV infection**

1. high-dose or long-term systemic corticosteroid therapy or other immunosuppressive/cytotoxic therapy ≤3 months before the onset of the indicator disease
2. any of the following diseases diagnosed ≤3 months after diagnosis of the indicator disease: Hodgkin's disease, non-Hodgkin's lymphoma (other than primary brain lymphoma), lymphocytic leukemia, multiple myeloma, any other cancer of lymphoreticular or histiocytic tissue, or angioimmunoblastic lymphadenopathy
3. a genetic (congenital) immunodeficiency syndrome or an acquired immunodeficiency syndrome atypical of HIV infection, such as one involving hypogammaglobulinemia

B. **Indicator diseases diagnosed definitively (*See* Appendix II)**

1. candidiasis of the esophagus, trachea, bronchi, or lungs
2. cryptococcosis, extrapulmonary
3. cryptosporidiosis with diarrhea persisting >1 month
4. cytomegalovirus disease of an organ other than liver, spleen, or lymph nodes in a patient >1 month of age
5. herpes simplex virus infection causing a mucocutaneous ulcer that persists longer than 1 month; or bronchitis, pneumonitis, or esophagitis for any duration affecting a patient >1 month of age
6. Kaposi's sarcoma affecting a patient < 60 years of age
7. lymphoma of the brain (primary) affecting a patient < 60 years of age
8. lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia (LIP/PLH complex) affecting a child <13 years of age
9. *Mycobacterium avium* complex or *M. kansasii* disease, disseminated (at a site other than or in addition to lungs, skin, or cervical or hilar lymph nodes)
10. *Pneumocystis carinii* pneumonia
11. progressive multifocal leukoencephalopathy
12. toxoplasmosis of the brain affecting a patient >1 month of age

## II. With Laboratory Evidence for HIV Infection

*Regardless of the presence of other causes of immunodeficiency (I.A),* in the presence of laboratory evidence for HIV infection (*See* Appendix I), any disease listed above (I.B) or below (II.A or II.B) indicates a diagnosis of AIDS.

**A. Indicator diseases diagnosed definitively (*See* Appendix II)**

1. bacterial infections, multiple or recurrent (any combination of at least two within a 2-year period), of the following types affecting a child < 13 years of age:

   septicemia, pneumonia, meningitis, bone or joint infection, or abscess of an internal organ or body cavity (excluding otitis media or superficial skin or mucosal abscesses), caused by *Haemophilus*, *Streptococcus* (including pneumococcus), or other pyogenic bacteria
2. coccidioidomycosis, disseminated (at a site other than or in addition to lungs or cervical or hilar lymph nodes)
3. HIV encephalopathy (also called "HIV dementia," "AIDS dementia," or "subacute encephalitis due to HIV") (*See* Appendix II for description)
4. histoplasmosis, disseminated (at a site other than or in addition to lungs or cervical or hilar lymph nodes)
5. isosporiasis with diarrhea persisting >1 month
6. Kaposi's sarcoma at any age
7. lymphoma of the brain (primary) at any age
8. other non-Hodgkin's lymphoma of B-cell or unknown immunologic phenotype and the following histologic types:
   a. small noncleaved lymphoma (either Burkitt or non-Burkitt type) (*See* Appendix IV for equivalent terms and numeric codes used in the *International Classification of Diseases*, Ninth Revision, Clinical Modification)
   b. immunoblastic sarcoma (equivalent to any of the following, although not necessarily all in combination: immunoblastic lymphoma, large-cell lymphoma, diffuse histiocytic lymphoma, diffuse undifferentiated lymphoma, or high-grade lymphoma) (*See* Appendix IV for equivalent terms and numeric codes used in the *International Classification of Diseases*, Ninth Revision, Clinical Modification)

   **Note:** Lymphomas are not included here if they are of T-cell immunologic phenotype or their histologic type is not described or is described as "lymphocytic," "lymphoblastic," "small cleaved," or "plasmacytoid lymphocytic"
9. any mycobacterial disease caused by mycobacteria other than *M. tuberculosis*, disseminated (at a site other than or in addition to lungs, skin, or cervical or hilar lymph nodes)
10. disease caused by *M. tuberculosis*, extrapulmonary (involving at least one site outside the lungs, regardless of whether there is concurrent pulmonary involvement)
11. *Salmonella* (nontyphoid) septicemia, recurrent
12. HIV wasting syndrome (emaciation, "slim disease") (*See* Appendix II for description)

**B. Indicator diseases diagnosed presumptively (by a method other than those in Appendix II)**

**Note:** Given the seriousness of diseases indicative of AIDS, it is generally important to diagnose them definitively, especially when therapy that would be used may have serious side effects or when definitive diagnosis is needed for eligibility for antiretroviral therapy. Nonetheless, in some situations, a patient's condition will not permit the performance of definitive tests. In other situations, accepted clinical practice may be to diagnose presumptively based on the presence of characteristic clinical and laboratory abnormalities. Guidelines for presumptive diagnoses are suggested in Appendix III.

1. candidiasis of the esophagus
2. cytomegalovirus retinitis with loss of vision
3. Kaposi's sarcoma
4. lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia (LIP/PLH complex) affecting a child <13 years of age
5. mycobacterial disease (acid-fast bacilli with species not identified by culture), disseminated (involving at least one site other than or in addition to lungs, skin, or cervical or hilar lymph nodes)
6. *Pneumocystis carinii* pneumonia
7. toxoplasmosis of the brain affecting a patient >1 month of age

### III. With Laboratory Evidence Against HIV Infection

With laboratory test results negative for HIV infection (*See* Appendix I), a diagnosis of AIDS for surveillance purposes is ruled out *unless*:

A. all the other causes of immunodeficiency listed above in Section I.A are excluded; **AND**
B. the patient has had either:
    1. *Pneumocystis carinii* pneumonia diagnosed by a definitive method (*See* Appendix II); **OR**
    2. a. any of the other diseases indicative of AIDS listed above in Section I.B diagnosed by a definitive method (*See* Appendix II); **AND**
        b. a T-helper/inducer (CD4) lymphocyte count $<400/\text{mm}^3$.

## COMMENTARY

The surveillance of severe disease associated with HIV infection remains an essential, though not the only, indicator of the course of the HIV epidemic. The number of AIDS cases and the relative distribution of cases by demographic, geographic, and behavioral risk variables are the oldest indices of the epidemic, which began in 1981 and for which data are available retrospectively back to 1978. The original surveillance case definition, based on then-available knowledge, provided useful epidemiologic data on severe HIV disease (*1*). To ensure a reasonable predictive value for underlying immunodeficiency caused by what was then an unknown agent, the indicators of AIDS in the old case definition were restricted to particular opportunistic diseases diagnosed by reliable methods in patients without specific known causes of immunodeficiency. After HIV was discovered to be the cause of AIDS, however, and highly sensitive and specific HIV-antibody tests became available, the spectrum of manifestations of HIV infection became better defined, and classification systems for HIV infection were developed (*2-5*). It became apparent that some progressive, seriously disabling, and even fatal conditions (e.g., encephalopathy, wasting syndrome) affecting a substantial number of HIV-infected patients were not subject to epidemiologic surveillance, as they were not included in the AIDS case definition. For reporting purposes, the revision adds to the definition most of those severe non-infectious, non-cancerous HIV-associated conditions that are categorized in the CDC clinical classification systems for HIV infection among adults and children (*4,5*).

Another limitation of the old definition was that AIDS-indicative diseases are diagnosed presumptively (i.e., without confirmation by methods required by the old definition) in 10%-15% of patients diagnosed with such diseases; thus, an appreciable proportion of AIDS cases were missed for reporting purposes (*6,7*). This proportion may be increasing, which would compromise the old case definition's usefulness as a tool for monitoring trends. The revised case definition permits the reporting of these clinically diagnosed cases as long as there is laboratory evidence of HIV infection.

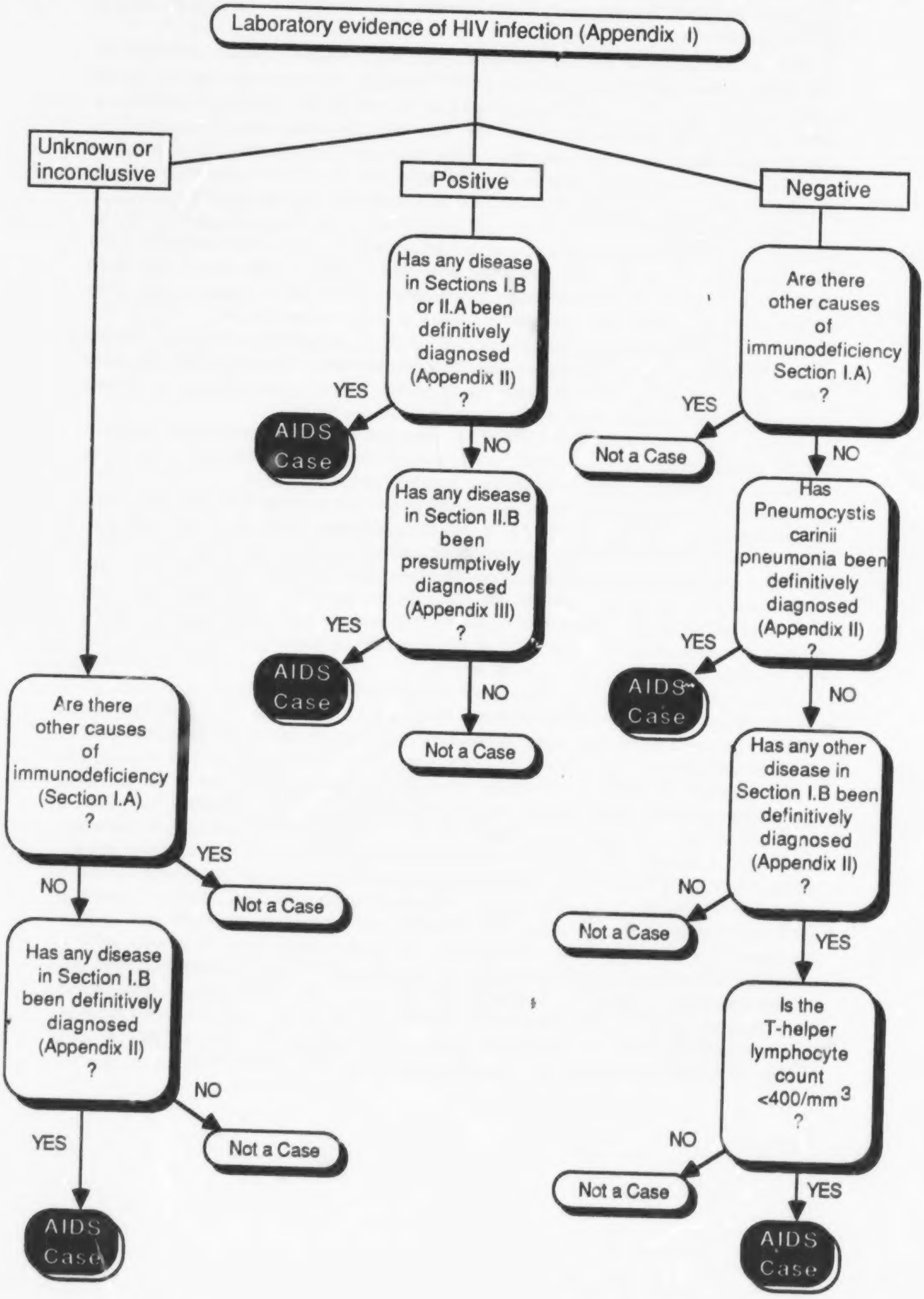
The effectiveness of the revision will depend on how extensively HIV-antibody tests are used. Approximately one third of AIDS patients in the United States have been from New York City and San Francisco, where, since 1985, < 7% have been reported with HIV-antibody test results, compared with > 60% in other areas. The impact of the revision on the reported numbers of AIDS cases will also depend on the proportion of AIDS patients in whom indicator diseases are diagnosed presumptively rather than definitively. The use of presumptive diagnostic criteria varies geographically, being more common in certain rural areas and in urban areas with many indigent AIDS patients.

To avoid confusion about what should be reported to health departments, the term "AIDS" should refer only to conditions meeting the surveillance definition. This definition is intended only to provide consistent statistical data for public health purposes. Clinicians will not rely on this definition alone to diagnose serious disease caused by HIV infection in individual patients because there may be additional information that would lead to a more accurate diagnosis. For example, patients who are not reportable under the definition because they have either a negative HIV-antibody test or, in the presence of HIV antibody, an opportunistic disease not listed in the definition as an indicator of AIDS nonetheless may be diagnosed as having serious HIV disease on consideration of other clinical or laboratory characteristics of HIV infection or a history of exposure to HIV.

Conversely, the AIDS surveillance definition may rarely misclassify other patients as having serious HIV disease if they have no HIV-antibody test but have an AIDS-indicative disease with a background incidence unrelated to HIV infection, such as cryptococcal meningitis.

The diagnostic criteria accepted by the AIDS surveillance case definition should not be interpreted as the standard of good medical practice. Presumptive diagnoses are accepted in the definition because not to count them would be to ignore substantial morbidity resulting from HIV infection. Likewise, the definition accepts a reactive screening test for HIV antibody without confirmation by a supplemental test because a repeatedly reactive screening test result, in combination with an indicator disease, is highly indicative of true HIV disease. For national surveillance purposes, the tiny proportion of possibly false-positive screening tests in persons with AIDS-indicative diseases is of little consequence. For the individual patient, however, a correct diagnosis is critically important. The use of supplemental tests is, therefore, strongly endorsed. An increase in the diagnostic use of HIV-antibody tests could improve both the quality of medical care and the function of the new case definition, as well as assist in providing counselling to prevent transmission of HIV.

FIGURE I. Flow diagram for revised CDC case definition of AIDS, September 1, 1987


Laboratory evidence of HIV infection (Appendix I)
Unknown or inconclusive
Positive
Negative
Has any disease in Sections I.B or II.A been definitively diagnosed (Appendix II) ?
YES
AIDS Case
NO
Has any disease in Section II.B been presumptively diagnosed (Appendix III) ?
YES
AIDS Case
NO
Not a Case
Are there other causes of immunodeficiency Section I.A) ?
YES
Not a Case
NO
Has Pneumocystis carinii pneumonia been definitively diagnosed (Appendix II) ?
YES
AIDS Case
NO
Has any other disease in Section I.B been definitively diagnosed (Appendix II) ?
NO
Not a Case
YES
Is the T-helper lymphocyte count <400/mm3 ?
NO
Not a Case
YES
AIDS Case
Are there other causes of immunodeficiency (Section I.A) ?
YES
Not a Case
NO
Has any disease in Section I.B been definitively diagnosed (Appendix II) ?
NO
Not a Case
YES
AIDS Case

*References*

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3. Redfield RR, Wright DC, Tramont EC. The Walter Reed staging classification of HTLV-III infection. N Engl J Med 1986;314:131-2.
4. CDC. Classification system for human T-lymphotropic virus type III/lymphadenopathy-associated virus infections. MMWR 1986;35:334-9.
5. CDC. Classification system for human immunodeficiency virus (HIV) infection in children under 13 years of age. MMWR 1987;36:225-30,235.
6. Hardy AM, Starcher ET, Morgan WM, et al. Review of death certificates to assess completeness of AIDS case reporting. Pub Hlth Rep 1987;102(4):386-91.
7. Starcher ET, Biel JK, Rivera-Castano R, Day JM, Hopkins SG, Miller JW. The impact of presumptively diagnosed opportunistic infections and cancers on national reporting of AIDS [Abstract]. Washington, DC : III International Conference on AIDS, June 1-5, 1987.

# APPENDIX I

## Laboratory Evidence For or Against HIV Infection

1. **For Infection**:
   When a patient has disease consistent with AIDS:
   a. a serum specimen from a patient ≥15 months of age, or from a child <15 months of age whose mother is not thought to have had HIV infection during the child's perinatal period, that is repeatedly reactive for HIV antibody by a screening test (e.g., enzyme-linked immunosorbent assay [ELISA]), as long as subsequent HIV-antibody tests (e.g., Western blot, immunofluorescence assay), if done, are positive; **OR**
   b. a serum specimen from a child < 15 months of age, whose mother is thought to have had HIV infection during the child's perinatal period, that is repeatedly reactive for HIV antibody by a screening test (e.g., ELISA), plus increased serum immunoglobulin levels and at least one of the following abnormal immunologic test results: reduced absolute lymphocyte count, depressed CD4 (T-helper) lymphocyte count, or decreased CD4/CD8 (helper/suppressor) ratio, as long as subsequent antibody tests (e.g., Western blot, immunofluorescence assay), if done, are positive; **OR**
   c. a positive test for HIV serum antigen; **OR**
   d. a positive HIV culture confirmed by both reverse transcriptase detection and a specific HIV-antigen test or in situ hybridization using a nucleic acid probe; **OR**
   e. a positive result on any other highly specific test for HIV (e.g., nucleic acid probe of peripheral blood lymphocytes).

2. **Against Infection**:
   A nonreactive screening test for serum antibody to HIV (e.g., ELISA) without a reactive or positive result on any other test for HIV infection (e.g., antibody, antigen, culture), if done.

3. **Inconclusive (Neither For nor Against Infection)**:
   a. a repeatedly reactive screening test for serum antibody to HIV (e.g., ELISA) followed by a negative or inconclusive supplemental test (e.g., Western blot, immunofluorescence assay) without a positive HIV culture or serum antigen test, if done; **OR**
   b. a serum specimen from a child < 15 months of age, whose mother is thought to have had HIV infection during the child's perinatal period, that is repeatedly reactive for HIV antibody by a screening test, even if positive by a supplemental test, without additional evidence for immunodeficiency as described above (in 1.b) and without a positive HIV culture or serum antigen test, if done.

# APPENDIX II

## Definitive Diagnostic Methods for Diseases Indicative of AIDS

| Diseases | Definitive Diagnostic Methods |
|---|---|
| cryptosporidiosis<br>cytomegalovirus<br>isosporiasis<br>Kaposi's sarcoma<br>lymphoma<br>lymphoid pneumonia or hyperplasia<br>*Pneumocystis carinii* pneumonia<br>progressive multifocal leukoencephalopathy<br>toxoplasmosis | microscopy (histology or cytology). |
| candidiasis | gross inspection by endoscopy or autopsy or by microscopy (histology or cytology) on a specimen obtained directly from the tissues affected (including scrapings from the mucosal surface), not from a culture. |
| coccidioidomycosis<br>cryptococcosis<br>herpes simplex virus<br>histoplasmosis | microscopy (histology or cytology), culture, or detection of antigen in a specimen obtained directly from the tissues affected or a fluid from those tissues. |
| tuberculosis<br>other mycobacteriosis<br>salmonellosis<br>other bacterial infection | culture. |

| | |
|---|---|
| HIV encephalopathy* (dementia) | clinical findings of disabling cognitive and/or motor dysfunction interfering with occupation or activities of daily living, or loss of behavioral developmental milestones affecting a child, progressing over weeks to months, in the absence of a concurrent illness or condition other than HIV infection that could explain the findings. Methods to rule out such concurrent illnesses and conditions must include cerebrospinal fluid examination and either brain imaging (computed tomography or magnetic resonance) or autopsy. |
| HIV wasting syndrome* | findings of profound involuntary weight loss >10% of baseline body weight plus either chronic diarrhea (at least two loose stools per day for ≥ 30 days) or chronic weakness and documented fever (for ≥ 30 days, intermittent or constant) in the absence of a concurrent illness or condition other than HIV infection that could explain the findings (e.g., cancer, tuberculosis, cryptosporidiosis, or other specific enteritis). |

---

*For HIV encephalopathy and HIV wasting syndrome, the methods of diagnosis described here are not truly definitive, but are sufficiently rigorous for surveillance purposes.

# APPENDIX III

## Suggested Guidelines for Presumptive Diagnosis of Diseases Indicative of AIDS

| **Diseases** | **Presumptive Diagnostic Criteria** |
|---|---|
| candidiasis of esophagus | a. recent onset of retrosternal pain on swallowing; **AND**<br>b. oral candidiasis diagnosed by the gross appearance of white patches or plaques on an erythematous base or by the microscopic appearance of fungal mycelial filaments in an uncultured specimen scraped from the oral mucosa. |
| cytomegalovirus retinitis | a characteristic appearance on serial ophthalmoscopic examinations (e.g., discrete patches of retinal whitening with distinct borders, spreading in a centrifugal manner, following blood vessels, progressing over several months, frequently associated with retinal vasculitis, hemorrhage, and necrosis). Resolution of active disease leaves retinal scarring and atrophy with retinal pigment epithelial mottling. |
| mycobacteriosis | microscopy of a specimen from stool or normally sterile body fluids or tissue from a site other than lungs, skin, or cervical or hilar lymph nodes, showing acid-fast bacilli of a species not identified by culture. |
| Kaposi's sarcoma | a characteristic gross appearance of an erythematous or violaceous plaque-like lesion on skin or mucous membrane.<br>(**Note**: Presumptive diagnosis of Kaposi's sarcoma should not be made by clinicians who have seen few cases of it.) |
| lymphoid interstitial pneumonia | bilateral reticulonodular interstitial pulmonary infiltrates present on chest X ray for $\geq 2$ months with no pathogen identified and no response to antibiotic treatment. |
| *Pneumocystis carinii* pneumonia | a. a history of dyspnea on exertion or nonproductive cough of recent onset (within the past 3 months); **AND**<br>b. chest X-ray evidence of diffuse bilateral interstitial infiltrates or gallium scan evidence of diffuse bilateral pulmonary disease; **AND**<br>c. arterial blood gas analysis showing an arterial $pO_2$ of <70 mm Hg or a low respiratory diffusing capacity (<80% of predicted values) or an increase in the alveolar-arterial oxygen tension gradient; **AND**<br>d. no evidence of a bacterial pneumonia. |

| | |
|---|---|
| toxoplasmosis of the brain | a. recent onset of a focal neurologic abnormality consistent with intracranial disease or a reduced level of consciousness; **AND**<br>b. brain imaging evidence of a lesion having a mass effect (on computed tomography or nuclear magnetic resonance) or the radiographic appearance of which is enhanced by injection of contrast medium; **AND**<br>c. serum antibody to toxoplasmosis or successful response to therapy for toxoplasmosis. |

# APPENDIX IV

## Equivalent Terms and International Classification of Disease (ICD) Codes for AIDS-Indicative Lymphomas

The following terms and codes describe lymphomas indicative of AIDS in patients with antibody evidence for HIV infection (Section II.A.8 of the AIDS case definition). Many of these terms are obsolete or equivalent to one another.

### ICD-9-CM (1978)

| **Codes** | **Terms** |
|---|---|
| 200.0 | **Reticulosarcoma**<br>lymphoma (malignant): histiocytic (diffuse) reticulum cell sarcoma: pleomorphic cell type or not otherwise specified |
| 200.2 | **Burkitt's tumor or lymphoma**<br>malignant lymphoma, Burkitt's type |

### ICD-O (Oncologic Histologic Types 1976)

| **Codes** | **Terms** |
|---|---|
| 9600/3 | **Malignant lymphoma, undifferentiated cell type**<br>non-Burkitt's or not otherwise specified |
| 9601/3 | **Malignant lymphoma, stem cell type**<br>stem cell lymphoma |
| 9612/3 | **Malignant lymphoma, immunoblastic type**<br>immunoblastic sarcoma, immunoblastic lymphoma, or immunoblastic lymphosarcoma |
| 9632/3 | **Malignant lymphoma, centroblastic type**<br>diffuse or not otherwise specified, or germinoblastic sarcoma: diffuse or not otherwise specified |
| 9633/3 | **Malignant lymphoma, follicular center cell, non-cleaved**<br>diffuse or not otherwise specified |
| 9640/3 | **Reticulosarcoma, not otherwise specified**<br>malignant lymphoma, histiocytic: diffuse or not otherwise specified reticulum cell sarcoma, not otherwise specified malignant lymphoma, reticulum cell type |
| 9641/3 | **Reticulosarcoma, pleomorphic cell type**<br>malignant lymphoma, histiocytic, pleomorphic cell type reticulum cell sarcoma, pleomorphic cell type |
| 9750/3 | **Burkitt's lymphoma or Burkitt's tumor**<br>malignant lymphoma, undifferentiated, Burkitt's type malignant lymphoma, lymphoblastic, Burkitt's type |

## NIH's DEFINITION OF AIDS-RELATED COMPLEX

At least 2 of the following clinical signs/symptoms lasting 3 or more months PLUS 2 or more of the following laboratory abnormalities, occurring in a patient having no underlying infectious cause for the symptoms and who is in a cohort at increased risk for developing AIDS.

Clinical:

1. Fever: >100°F, intermittent or continuous, for at least 3 months, in the absence of other identifiable causes.
2. Weight Loss: 10% or ≥15 lbs.
3. Lymphadenopathy: persistent for at least 3 months, involving ≥2 extra-inguinal node bearing areas.
4. Diarrhea: intermittent or continuous, ≥3 months, in the absence of other identifiable causes.
5. Fatigue, to the point of decreased physical or mental function.
6. Night Sweats: intermittent or continuous, ≥3 months, in the absence of other identifiable causes

Laboratory:

1. Depressed helper T-cells (≥2 standard deviations below mean).
2. Depressed helper/suppressor ratio (≥2 standard deviations below mean).
3. At least one of the following: leukopenia, thrombocytopenia, absolute lymphopenia or anemia.
4. Elevated serum globulins.
5. Depressed blastogenesis (pokeweed and PHA).
6. Abnormal skin tests (using Multi-Test or equivalent).

# APPENDIX C

## Iowa Department of Corrections AIDS Screening: Health History

DEPARTMENT OF CORRECTIONS
Iowa Medical and Classification Center
Health Services

## AIDS SCREENING: HEALTH HISTORY

1. Inmate Number ____________ 2. Admit Date ____________
3. Sex: _____Male _____Female 4. Birthdate ____________
5. Height ________ 6. Weight ________ 7. BP ______ 8. PPD ________
9. Ethnic Background: _____White _____American Indian
_____Black _____Other ____________
_____Hispanic (i.e., Cuban, Puerto Rican, Mexican)

10. USE OF IV DRUGS: History of IV drug use _____Yes _____No

If Yes: a. Date of last usage ____________
b. Avg. frequency of use ____________
c. Duration of use (mos./yrs.) ____________
d. Shared needle usage _____Yes _____No

11. USE OF OTHER DRUGS: _____Yes _____No

If Yes: a. Circle types: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15
b. Date of last usage ____________
c. Avg. frequency of use ____________
d. Duration of use (mos./yrs.) ____________
e. Poppers (Amyl Nitrate): _____Yes _____No

12. USE OF ALCOHOL: _____Yes _____No

If Yes: a. Date of last usage ____________
b. Avg. frequency of use ____________
c. Duration of use (mos./yrs.) ____________

13. SEXUAL HISTORY:

a. Age of 1st sexual contact ____________
b. Number of different sexual contacts per week/month ____________
c. Approximate date of last contact ____________
d. Sexual preference: _____heterosexual; _____bisexual; _____homosexual
e. If male bisexual or homosexual:

1. Date of last homosexual activity ____________
2. Average frequency of homosexual activity (per wk./mo.) ____________
3. Duration of homosexual activity (mos./yrs.) ____________
4. Anal intercourse _____Yes _____No

If Yes: Anal initiator _____
Anal recipient _____
Both _____

5. Oral intercourse _____Yes _____No
6. Fist intercourse _____Yes _____No
7. Number of different partners per month ____________

f. Frequency of use of condoms: _____always; _____sometimes; _____never

14. Have you been outside of Iowa since 1975? ______Yes ______No

If Yes:
- a. List states______________________________
- b. When (year)______________________________
- c. Length of stay (mos./yrs.)______________________
- d. If in prison, how long________ What states________________

15. HAVE YOU RECEIVED BLOOD/BLOOD PRODUCTS SINCE 1975? ______Yes ______No

If Yes:
- a. When______________________________
- b. Kinds______________________________
- c. Amount______________________________

16. SYMPTOMS AND SIGNS OF AIDS:

| | Yes | No | Onset |
|---|---|---|---|
| a. Unexplained, persistent fatigue | ____ | ____ | __________ |
| b. Unexplained fever, shaking, chills, or drenching night sweats lasting longer than several weeks | ____ | ____ | __________ |
| c. Unexplained weight loss greater than 10 pounds | ____ | ____ | __________ |
| d. Unexplained swollen glands lasting longer than two weeks | ____ | ____ | __________ |
| e. Unexplained skin changes, especially purplish blotches or bumps, or bruises that do not disappear | ____ | ____ | __________ |
| f. Persistent white spots or blemishes in the mouth | ____ | ____ | __________ |
| g. Persistent diarrhea | ____ | ____ | __________ |
| h. Persistent dry cough, not associated with URI | ____ | ____ | __________ |

17. HISTORY OF HEPATITIS: ______Yes ______No

If Yes:
- a. What type______________________________
- b. When______________________________
- c. _____Hospitalized or ______Outpatient

18. HISTORY OF STD: ______Yes ______No

If Yes: a) Warts____; b) Herpes_____; c) Gonorrhea_____; d) Chlamydia_____
e) Nonspecific vaginitis/urethritis_____; f) Other ______________

19. PREVIOUS TEST(S) FOR AIDS VIRUS: ______Yes ______No

If Yes:
- a. Where______________________________
- b. Results______________________________

20. HIV ANTIBODY TEST: Date Drawn:______________ Results____________________

21. WBC__________ mm$^3$
Differential: ______% segs.; ______% bands; %______eos.; ______% basos.;
______% lymphs.; ______% monos.; ______% morph.

Completed by______________________________ ____________________
Signature/Title Date Completed

12/18/86

# APPENDIX D

## Examples of Training Materials
## and
## Policy Directives

- *Maricopa County, Arizona Adult Probation Department Guidelines (Sections I and II)*
- *State of New Jersey Administrative Office of the Courts, Probation Services (pp. 8-12)*
- *New York State Parole Operations (Section III, pp. 3-11)*

best copy available

Maricopa County, Arizona
Adult Probation Dept.

## COMMUNICABLE-CONTAGIOUS DISEASES DUTIES, RESPONSIBILITIES AND LIABILITIES

**Authority:** Common Sense

**Purpose:** To Establish A Policy Upon Which Decisions Can Be Reached By Staff In The Supervision, Treatment And Surveillance Of Probationers Known To Have Communicable, Contagious Diseases And/Or Be In Identifiable High-Risk Environments For Said Diseases. This Policy Is Intended To Address The Following Areas And Issues.

I. Definitions
II. Officer Responsibilities
III. Duty 'to Supervise and Officer Liability
IV. Client Privilege/Privacy vs Public Need-To-Know
V. Duty To Inform Issues
VI. Probationer Testing Procedures
VII. Officer and Probationer Safety and Welfare.

**Policy:**

**Introduction:** With increasing frequency persons sentenced to probation are known, or may be diagnosed while under supervision, to have a communicable and contagious disease such as AIDS and hepatitis. In many instances it is appropriate, either because of statutory requirement, Court directive or care needs that a treatment regimen prevail, including urinalysis or breath/intoxilyzer testing. Anyone under probation supervision with a confirmed diagnosis as actively contagious presents special needs: the statutory or Court directive must be complied with and a duty to supervise attaches to probation staff. This duty must be carried out in a safe and secure environment that protects staff, maintains the probationer's rights and serves and protects the public's welfare. This policy is intended to provide the procedures, safeguards and direction to effectively accomplish all these objectives.

## I. Definitions:

### A. Communicable-Contagious Disease:

Any disease or infectious condition that is actively contagious and transmittable, in deference to the mode of transmission. Diseases and afflications include, but are not limited to:

AIDS (HLV IV Virus)
Infectious Hepatitis
Rubella (German Measles)
Viral Encephalitis

DRAFT

### B. Persons At High Risk (PAHR):

Any person whose history includes illicit IV-drug usege or any person who has had, or does have, intimate social and/or sexual relationships with illicit IV-drug users, PWA's and/or persons identified in populations of greater incidence of AIDS, hepatitis or related contagious diseases.

### C. PWA:

Person(s) with AIDS.

### D. Officer:

Any probation or surveillance officer of the department or any clerical staff, volunteer, intern or other person who may be delegated duties relating to supervision or presentence activities involving potential contact with persons with communicable-contagious diseases.

DRAFT

## II. Officer Responsibilities:

### A. PSI:

1. If during the course of the presentence investigation a person claims he or she has any active communicable disease; i.e., AIDS or hepatitis, fears he or she may be infected, lives with someone having such a disease or classifies as a high-risk class offender, the officer shall inquire and request copies of any medical tests of certification of the disease. Requests for medical *Release of Information* for physicians, hospitals or agencies treating the person shall be made.

2. In any case where a person admits or acknowledges that they have a communicable disease during the presentence investigation, the officer should inform the person the fact will be reported to the Court. This information, including whether it is verified by medical personnel or an unverified assertion should be cited in the presentence report in the Social History section. Furthermore in ALL such cases the officer should prepare a special Incident Report and request that support staff type in this incident on the blue chronie sheet of the case file. The incident should be as comprehensive as possible and list the treating physician, support group or other relevant information and reference any documentation in file.

3. If a person asserts he or she is contagious but demands privacy under a doctor-patient privilege, or if an officer assesses the person to fit the PAHR profile, said information should be included in a special Incident Report for the file via the blue chronie page. In these instances no reference shall be made in the PSI to the person's assertions or officer assessment.

DRAFT

### B. Field Supervision or IPS:

If a person is under supervision who has admitted or acknowledged having a communicable disease, all supervision plans and treatment decisions should take into account the factor:

a. If a person's disease and contagion have been medically certified, officers shall procure medical releases and coordinate all supervision planning, including residential status, employment and WOP/CSH placement with the treating physician and/or disease-specific support group that may be involved.

b. If a person alleges or believes he or she may be actively contagious, officers shall attempt to make diagnostic referrals to appropriate medical professionals for verification and/or certification. Officers may utilize an implementation form to require probationers to submit to testing.

c. Any person evaluated to be a PAHR shall be treated as if they are contagious and should be referred by the officer on a case-by-case basis to public health presentations or counseling/support groups. Further a person under supervision who remains in an environment of a PAHR may be periodically referred for medical testing at an officer's discretion.

d. All activities relating to communicable-contagious diseases of any probationer in a., b., or c. shall be scrupulously documented in a probationer's case file.

Robert D. Lipscher
Administrative Director of the Courts

Harvey M. Goldstein
Assistant Director for Probation

# FINAL REPORT OF THE

# PROBATION COMMITTEE ON AIDS

Administrative Office of the Courts
Probation Services
Justice Complex, CN-987
Trenton, NJ 08625

July 1987

## DISCUSSION

The best available scientific information indicates that AIDS is transmitted through exchange of internal body fluids (blood and semen) in intimate sexual relations or activities engaged in by a small subgroup of IV drug users. These behaviors do not occur during the regular conduct of probation supervision. Since the risk of transmission at the work place is very low, few change in probation policies are warranted.

While there is no reason to make extraordinary modifications in procedures, any risk at all is a cause for concern given the fact that AIDS is almost always fatal. Probation administrators must take prudent action to develop policies consistent with the best scientific knowledge, agency priorities and social conscience. A prominent researcher has noted..."right now, our only tools [for controlling AIDS] are education and behavior change."[5]

Probation's response to the challenge of AIDS must balance several competing interests, all compelling in their own right. The safety of staff must be protected by reducing the risk of exposure. The rights of the person with AIDS to services and to a degree of dignity must be protected. Persons with AIDS could easily become social outcasts. The rights of society to enforcement of court orders and protection through supervision cannot be forgotten.

Because of the long incubation period for AIDS, infected persons are able to carry and transmit the virus without themselves showing symptoms. Those who have contracted the disease or carry the virus may remain quite able to continue behavior associated with transmission for some time. If they still use intravenous drugs and probation does not take appropriate steps to stop them, probation is not only remiss in its duty but indirectly contributes to the spread of the disease. In that regard, probation is obligated to work toward assuring the discontinuation of intravenous drugs use.

Probation also has a role to educate persons under its supervision about AIDS and high risk behavior and to locate and make available the appropriate services for infected probationers. Historically, probation has located and provided services for those in much less severe need. The person with AIDS is an individual in the most desperate need. Probation has a moral obligation to respond.

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[5] Dr. Harold Jaffe of the Centers for Disease Control, addressing a NIC-sponsored meeting of correctional administrators, November 6, 1985.

## RECOMMENDED STRATEGY TO RESPOND TO AIDS

Probation's response to AIDS includes procedural changes and education. Modified supervision policies for infected probationers and training for staff are designed to achieve safety without sacrificing the integrity of supervision.

### Training

Staff training will educate probation personnel about the disease and reduce the level of fear and anxiety which exists. In turn, probation staff will be able to provide accurate information to others, including probationers and court personnel.

The New Jersey Department of Health has been providing training about AIDS for some time and has maintained the most up to date information. In order to provide quality training in a timely fashion, the AOC Training Unit has utilized trainers from the Department of Health to conduct sessions for probation staff.

The AOC Training Unit staff will maintain a liaison with staff of the Department of Health to monitor developments in this area, and provide additional training and/or information as it becomes appropriate.

### Verification and Medical Treatment

A probation staff member may learn of AIDS infection from a probationer or other reliable source. Those with AIDS will probably be getting medical treatment. Therefore, the simplest and most reliable way of verifying an HIV infection is through the medical provider who informed the probationer of the infection, e.g., the doctor, clinic, the HIV antibody testing site, etc.

The medical provider should be contacted in writing, either directly or by having the probationer hand-carry a written request for information, to verify an AIDS diagnosis or other stage of HIV infection. The provider should respond in writing on letterhead or prescription form. Because of the highly confidential nature of this information, the first step must be to have the probationer sign a specific records release authorization, a copy of which would accompany any written communication to the medical provider. (Having the probationer hand-carry such a request may expedite matters by allowing the provider to receive personal verification of permission to release the information.)

If this process is unsuccessful, for whatever reason, and the HIV infection reported by the probationer or some other source is still suspected, then an HIV antibody test should be considered as an alternative means to verify infection. The need for an HIV antibody test should be carefully discussed with the probationer. Information should be provided about the potential for discriminatory use of test results should they become known, for example, in the insurance and housing markets. (New Jersey has no state law safeguarding against such discrimination.) Then a referral should be made to either a state-funded counselling and testing site where confidentiality is strictly guarded, or to another medical provider mutually agreed upon, where confidentiality may or may not be securely preserved. (See Appendix C for a listing.)

If a probationer is reluctant or refuses to submit to antibody testing, the probation staff should make every effort to convince the probationer of the need for testing for personal and public health reasons. Should these efforts fail to persuade the probationer, the case should be referred to the sentencing judge for action in obtaining cooperation.

If probationers with HIV infection are not getting adequate medical treatment, probation staff should encourage them to do so and assist with referrals to appropriate facilities. (See Physicians' Referral List in Appendix C.) This is very important because life-threatening symptoms can develop very quickly. If the probationer's permission is given, medical personnel may be able to provide information to the probation staff which will assist in supervision.

## Confidentiality

Persons with AIDS, ARC, or HIV infection run a significant risk of becoming social outcasts. Probation staff should exercise caution in revealing information about infected persons. Normal restrictions apply, but the potentially damaging nature of this information requires careful exercise of discretion. Therefore, information on AIDS infection should be revealed only to those individuals who absolutely must know to effect successful supervision.

## Urine Monitoring

Screening for drug use gains importance due to the high risk of transmission of the virus through sharing of needles. Probation staff involved with urine monitoring should follow the procedures developed for use by the Centers for Disease Control, as adopted by the state Intensive Supervision Program. (See Appendix D.) **THESE PROCEDURES SHOULD BE FOLLOWED FOR ALL URINE SPECIMENS BECAUSE THEY ARE EFFECTIVE CONTROLS FOR ANY COMMUNICABLE DISEASE.** (See also Appendix E.)

## Education

With the overlap of one high risk AIDS group (IV drug users) and the probation population, educational materials should be readily available in the probation offices including informational brochures and posters. Staff should be knowledge about AIDS, but when they are unable to answer probationers' specific questions, referral should be made to the New Jersey AIDS Hotline (1-800-624-2377) or other reliable sources listed in Appendix F.

## Supervision

### Policy Statement

The probation departments and their employees shall provide supervision and services to all persons placed under their jurisdiction by the courts, despite a suspected or confirmed diagnosis of AIDS or HIV infections.

Probation supervision activities should not be eliminated in the face of AIDS, but some modifications may need to be incorporated into standard operating procedures on a case-by-case basis.

### Supervision Contacts

Probation staff should continue to provide supervision to persons verified to be HIV infected. If an HIV infected person's medical condition would rule out or prevent benefiting from a face-to-face personal contact (e.g., probationer is bedridden or hospitalized due to secondary illness), collateral contacts should be an option.

## Testing

A variety of questions remaining about HIV antibody testing lend themselves to resolution through policy promulgation by the courts. These issues include the following.

...Can the courts compel testing?
...If so, should they?
...For whom?
...Where should testing be done?
...Who should pay for it?

Probation officers and other appropriate judicial employees need to be trained about the advantages and disadvantages of testing. They should also be given the skills and sensitivity needed to counsel probationers on this subject and the knowledge of where to refer for testing and counseling.

Although there is no known cure for AIDS, testing is still advisable for a number of reasons. If the individual to be tested does not have AIDS, the test can provide reassurances. The results are not foolproof, but they are accurate enough to relieve some of the fear and anxiety associated with the disease. On the other hand, if positive test results are found, certain medications may be beneficial while new ones could be discovered at any time. Also, modifications of certain behaviors may slow the progress of the disease or help to prevent the onset of opportunistic infections. Equally important, changes in habits or life styles could help significantly in limiting the spread of infection to others. (See Appendixes G and H.)

The most reasonable stance to take on this issue seems to be an avoidance of wholesale testing in favor of a selective approach based on individual case circumstances. One important criterion should be to conduct tests whenever an individual is put at risk by another person's actions. In such cases as rape or other type of assault where the possibility of infection is present, testing should be done on the perpetrator if at all possible and the results shared with the victim if that person wants to know them. If for any reason the perpetrator cannot be tested, then the victim should be counseled about the advisability of being tested.

# AIDS
# INFORMATION GUIDE

Parole Operations
April 1986

New York State
MARIO M. CUOMO
Governor

Division of Parole
RAMON J. RODRIGUEZ
Chairman

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## SECTION III - QUESTIONS AND ANSWERS ABOUT AIDS

1. Q: According to the prison grapevine, we have an inmate in population, who has AIDS who has not been officially "diagnosed" as such by DOCS and added to their roster. Why aren't we being told and what should we do to find out?

A. The prison grapevine cannot be relied on as being totally accurate, and with an issue as emotionally charged as this one, is likely to be greatly exaggerated. There have, however, been instances where an official diagnosis of AIDS only confirms that which has been suspected, but unofficial.

There is no simple answer as to why this occurs. In part it is the result of less than perfect communication between DOCS and DOP; that situation should be greatly improved with the now regular exchange of information between our agencies on these cases. In part, suspicions of inaccurate reporting stem from the fact that people can only be diagnosed as having AIDS or ARC after a very specific set of medical circumstances have been satisfied—and great care must be taken not to misdiagnose, thereby leaving an individual permanently stigmatized by such an error. Finally, in some instances DOCS Health Services staff may not be aware of an inmate's illness and therefore cannot treat or report it.

In order to uncover medical problems requiring treatment, all new DOCS admissions receive a medical evaluation upon arrival in the correctional system. In addition, DOCS is required to provide periodic follow up medical exams on all inmates. If test results indicate abnormal findings, the inmate is referred to a community hospital for a complete evaluation. All confirmed AIDS and ARC cases are placed in the facility infirmary or community hospital.

DOCS facility Health Services staff are, by law, precluded from discussing a patient's medical diagnosis with anyone other than Health Services staff without the patient's permission. The Health Services Unit provides DOP with a list of all AIDS and ARC cases and medical summary information for purposes of discharge planning. This information provided to Parole should be treated with the utmost confidentiality as is required by law, and should not be disclosed without the permission of the patient to anyone other than Division of Parole or DOCS Health Services staff.

No inmate identified as having a communicable disease, known to Health Services, remains in population untreated. Bear in mind, however, that inmates have the right to seek, or to refuse to seek, health care. Obviously DOCS lists of AIDS/ARC cases will not include inmates whom you suspect might be ill but who have not come forth for treatment.

Questions about any such cases should be directed to the facility Health Services Director or Nurse Administrator for clarification. Bear in mind, however, that DOCS cannot provide information on cases that have not been diagnosed.

2. Q: I recently interviewed an inmate in population who looked pretty ill, and while he didn't say so directly, I got the feeling from his description that he may think he has early symptoms of AIDS. He hasn't elected to be seen by the Health Services Unit nor has he discussed this with any DOCS personnel. What should I do about this?

A: In addition to counseling the inmate about the serious implications for himself and others with whom he has contact if he is in fact ill, you should urge him to seek medical attention and assist him to do so in any ways that are appropriate. At a point, however, if the inmate fails to contact medical staff and you have reason to believe he is ill, you have an obligation to discuss the situation with the DOCS facility Health Services Physician or Nurse Administrator.

Keep in mind, however, that medical treatment cannot be imposed by force, and the DOCS Health Services staff can only treat inmates who come forth for such treatment.

3. Q: I'm not a Parole Officer, but I'm still worried about having contact with inmates or parolees with AIDS. Can I get AIDS by being near them or processing paperwork on them?

A: No. AIDS is not transmitted through the air, food or water, or by touching any object handled, touched or breathed on by a person with AIDS. There is no indication that AIDS is spread through any form of casual contact. AIDS cannot be transmitted by a routine office contact with inmates or parolees with AIDS.

4. Q: If I am working with an inmate or parolee with AIDS, will my family be in danger of getting infected?

A: AIDS is not an easily transmissible disease and there is no evidence that it can be transmitted through air, water, food or casual contact. Since you are personally not at risk of getting AIDS as a result of the routine contact you have with an inmate or parolee with the disease, your family suffers no risk of exposure or infection as a result.

The largest study to date of AIDS patients and their families, undertaken by the Montefiore Center in New York City, has unearthed no evidence of transmission of the virus to household members who have shared household items and facilities and had close personal interaction with the patient. The study indicates that household contacts who are not sexual partners of, or born to, patients with AIDS are at minimal or no risk of infection with HTLV III. Copies of the Montefiore Study can be obtained by contacting the Regional AIDS Liaison.

5. Q: In preparation for a Pre-Board Summary, I will be interviewing an inmate who has AIDS and is in the prison infirmary. How do I know what precautions to take?

A: Just as you would for any inmate being treated for a communicable illness, consult the DOCS facility Nurse Administrator to determine what, if any, precautions are advised for DOCS staff and Parole Officers. (Note: For epidemiological and medical purposes, AIDS is not classified as a communicable disease.)

6. Q: Can I conduct my Pre-Board Summary interview with an inmate with AIDS by telephone?

A: There is no medical evidence to suggest that AIDS is transmitted through casual contact. In most instances these interviews can be safely conducted in a face-to-face contact; face-to-face interviews with these inmates shall be the expected standard. Where, however, facility medical staff recommend that face-to-face contact not take place, after consultation with the Senior Parole Officer, a telephone interview may be arranged.

In all instances where deviation from the face-to-face interview procedure occurs, an entry shall be made in the inmate's case record stating the basis on which such a decision was rendered. Written notice of all such actions shall be forwarded to the Area Supervisor with a copy to the Parole Services Program Specialist.

7. Q: Inmates with AIDS who are scheduled to appear before the Parole Board are often not ambulatory and may not be present at a given facility on their Board date. What can these inmates expect with regard to Board action in their cases?

A: An ambulatory inmate with AIDS who is in the facility infirmary should appear before the Parole Board in the Parole Board room if at all possible. A non-ambulatory inmate with AIDS who is in the facility infirmary will, if necessary, be visited by the Parole Board members in the infirmary. Institutional Parole staff are responsible for coordinating with Correction staff to insure that appropriate arrangements for these interviews are made.

An inmate with AIDS who is in the community hospital and is unable to appear or be seen at the facility infirmary will, if an initial applicant, be postponed for no more than two months or earlier to determine the arrangements necessary to accomplish the Parole Board appearance. Once a determination has been made, arrangements should be implemented without delay. In most instances this will include an assignment of a special panel of the Parole Board to conduct the parole interview at the community hospital. In the event an inmate with AIDS is scheduled to return to the correctional facility and the medical condition indicates no emergent need to provide an on-site community hospital visit, the inmate will be scheduled for the next available Board at the facility of return.

In reappearance cases where the inmate is in a community hospital, the Board will direct an immediate and expeditious investigation with regard to the inmate's medical condition. As a rule, this period of investigation by the institutional Parole Officer should not exceed two to three weeks and should result in a report to the Board concerning the seriousness of the disability and the likelihood of return to the institutional setting. Based upon a case-by-case decision following review of this report, the Board will make a determination relative to the urgency attached to an on-site community hospital Board appearance. Where return to the facility by the inmate can be anticipated, the inmate will be seen at the next Board panel visit at the facility. Otherwise, a special panel will be assigned to conduct the parole interview at the community hospital.

It is the responsibility of the Senior Parole Officer at the institution to insure that all necessary information and reports are prepared for the Board in a timely and enhanced fashion in order to eliminate unnecessary delay in these cases. If there is a need to discuss plans for the Board interview in advance, Parole staff should contact the Executive Secretary to the Board of Parole to discuss the case.

8. Q: What should I do if an inmate with AIDS or ARC is transferred from my institution to another prison?

A: The Parole Transfer Summary prepared in these cases should be "flagged" in order to alert the receiving Parole Office that the case requires special attention, similar to the manner in which cases involving T.B. or extreme suicidal tendencies are identified. All available information concerning the inmate's medical condition should be noted in the summary, as well as any immediate needs of the inmate which would have an impact on the receiving facility.

9. Q: An inmate with AIDS who is currently hospitalized is scheduled for parole/CR to a hospital program. He wants to be released to a hospital closer to home. Who's responsible for making hospital transfer arrangements and providing transportation?

A: The Division of Parole is committed to taking the initiative in providing leadership to ensure the development of comprehensive release plans in these cases. Division staff bear bottom line responsibility for release planning. Parole staff must take the lead in coordinating the development of the release program and expedite the completion of program plans.

Under these circumstances, an inmate would be released to an approved program in the same manner as any other inmate, that is, via the Community Preparation process. In completing the community preparation assignment, i.e., developing a hospital program, the field Parole Officer will need to identify appropriate community medical facilities, working in conjunction with community resources (e.g., AIDS Task Force) and institutional Parole and DOCS staff.

As with other releasees, DOCS is responsible for arranging transportation in accordance with the release plan and established procedures. Frequently, to facilitate a transfer of this sort, DOCS may grant a medical leave of absence to a community hospital or transfer the inmate to a correctional facility closer to his parole destination. Division Staff should explore arrangements of these sorts where deemed necessary with appropriate DOCS Staff (Health Services or Temporary Release).

(Note: In cases where an inmate has been granted a medical leave of absence, signing of the Certificate of Release to Parole Supervision (Form 3010), typically handled by the Parole Officer in the institution, will be the responsibility of the Parole Officer in the field.)

10. Q: I can't get a residence for an inmate with AIDS -- his family is afraid to let him come home. Can I refer him to a Parole Resource Center? How?

A: Under these circumstances and with the consent of the inmate, a clear statement of medical diagnosis and status with relevant back-up documentation (e.g., the DOCS Medical Discharge Summary) must accompany the PRC referral. In accordance with the contractual agreement between the Division and residential service providers, individuals having medical problems beyond the capacity of the program to address may be refused admission by the program. This may well be the case with releasees with AIDS who require intensive or specialized treatment.

Before resorting to a PRC program, however, you may find that by making counseling and information available to families you are able to dispell some of their fears and misconceptions. Resources to assist in this process can be identified through Regional AIDS Task Forces, as well as by DOCS Ministerial and Family Services.

11. Q: I'm trying to work out a release plan for an inmate with AIDS who was recently hospitalized. His condition seems to change rapidly and I'm having trouble assembling a suitable plan. Who can help me with this?

A: Release plans in these cases should be built on medical information provided by DOCS facility Health Services Units through Medical Discharge Summaries. These plans should be comprehensive enough to anticipate possible changes in medical status and should include alternatives for community-based hospital and outpatient care.

In addition to DOCS facility Health Services staff, Regional AIDS Task Forces and DOP Regional AIDS Liaisons are resources as you develop these plans.

12. Q: When I am assigned the Community Preparation investigation on an inmate with AIDS or ARC, how do I know if the inmate has been informed of the diagnosis, if he has accepted his medical condition and told people who need to know about it, especially lovers or roommates?

A: This information should be included in the Medical Discharge Summary form prepared by DOCS facility Health Services staff and forwarded to the institutional Parole Officer. This form addresses specifically whether the diagnosis is known by the patient and/or family. In addition, the institutional Parole Officer should discuss these issues with the inmate in the interview for the Parole Board Summary and in subsequent contacts. The fact that an inmate has AIDS, and other information pertinent to this condition, should be mentioned in the medical status section of the Parole Board Summary to which the Medical Discharge Summary is attached.

If the field Parole Officer responsible for the community preparation investigation does not feel that this report is explicit enough with respect to the circumstances of the inmate's medical status, he should contact the institutional Parole Officer responsible for the preparation of the Summary and ask to be provided with additional information. The field Parole Officer should not initiate direct contact with DOCS facility Health Services staff, rather should rely on the institutional Parole Officer's relationship with the facility's Health Services staff to obtain any needed information.

13. Q: I've been assigned the Community Preparation investigation on an inmate approaching release who has AIDS. Although the Parole Officer in the institution has counseled him about responsible behavior in light of his medical condition, he has not yet told the person with whom he plans to live that he has AIDS. Can I tell?

A: Inmates have a federally protected right to confidentiality, which prohibits the disclosure of medical information without the inmate's permission. Absent this permission, Parole staff may not disclose this information. Any person revealing information of this sort without the necessary release form signed by the inmate may be liable for violating these federally protected rights.

We should exhaust every resource to avoid these situations. While it may not be an easy task, Parole Officers must use all of their skills to provide counseling that enables inmates with AIDS or ARC to behave in a responsible manner with regard to their medical condition.

14. Q: Can I disapprove an inmate's residence plan if he refuses to tell the person with whom he will be living that he has AIDS or ARC?

A: An inmate with AIDS or ARC may choose to exercise his federally protected right to confidentiality by refusing to reveal his medical condition, even to a roommate. We cannot deny release based on the exercise of this right. While you can and should urge the inmate to disclose this information and explore alternatives with him, in the final analysis, a residence plan that is acceptable in all other respects cannot be rejected for this reason.

15. Q: I'm doing the Community Preparation investigation on an inmate with AIDS. The Parole Officer in the institution describes him as asymptomatic. He has an offer of employment. Should I tell his employer about his medical condition or disapprove his employment?

A: Again we are faced with the same issue of protected rights and confidentiality. Employment can be disapproved only if a relationship exists between the inmate's crime and the proposed job. Since AIDS is not transmitted by casual contact, and requires sexual intercourse or the sharing of needles or exchange of blood, legitimate employment is not likely to present an opportunity for transmission of the disease.

Therefore, a diagnosis of AIDS or ARC is not a basis to deny employment, and you are prohibited from disclosing this condition to an employer without the necessary release forms signed by the inmate.

16. Q: An inmate is conditionally released without prior notice to the receiving field office. A check of the releasee's case folder indicates that he was diagnosed as having AIDS. What resources are available to assist the Parole Officer in developing a program?

A: The institutional Parole Office should be contacted and all available data reviewed to determine whether a program was previously proposed or developed. If no such tentative plan exists, appropriate local resources should be utilized (e.g., Regional AIDS Task Forces and county social services departments).

17. Q: An inmate with AIDS who is being released has been assigned to my caseload. Should I keep him from coming into the office by putting him on non-report status?

A: The issue here is whether the parolee's medical condition is so fragile that he is incapable of reporting or whether he is so immune suppressed that reporting would endanger him. These are decisions which depend on an individual's current medical status, and should be made on a case-by-case basis based on medical status.

Parolees with AIDS or ARC may be excused from office reports in keeping with the provisions of Field Services Manual Item 9204.00, Caseloads in

Supervision. These decisions must be made in consultation between the Parole Officer and Senior Parole Officer, be based on current medical status, and be reflected in notes in the parolee's folder. As in any case where there is a diminution of supervision contacts, alternative means to establish contact should be fully utilized.

All cases where a releasee is excused from office reports shall be reviewed monthly by the Senior Parole Officer to determine whether the basis for such a decision is still valid. Documentation of such periodic reviews shall be included in the releasee's case record.

Written notice shall be forwarded to the Area Supervisor with a copy to the Parole Services Program Specialist in all cases where a releasee with AIDS or ARC is excused from regular office reports, with periodic updates in keeping with the requirement for monthly review of such decisions.

18. Q: I have a couple parolees on my caseload who have been diagnosed as having AIDS, and another whom I suspect. Won't I be in danger of getting AIDS when I make home visits?

A: As stated previously, there is no indication that AIDS can be transmitted through any form of casual contact and routine home visits should not pose any risk. In these cases, Parole Officers are expected to meet all standards and requirements of supervision, with the exception already described concerning office reports. Prudence would dictate that in the absence of office reports, the purpose served by these contacts must be accomplished by other means, in particular home visits. As in all other situations, as dictated by the specific needs of the case, additional contacts should be made as are appropriate.

19. Q: In supervising a releasee in the community who has AIDS, how do I know what precautions are recommended based on the releasee's current medical status?

A: Field Parole Officers should obtain the written consent of the releasee in order to establish contact with community medical professionals treating the releasee. Information germane to the issues of supervision and casework would be: is the releasee able to travel; what medication(s) is the releasee taking; are there special services needed by the releasee; can the releasee work; what is the releasee's current medical status.

Obviously, as the releasee's condition changes, so will responses to these questions and the nature of parole casework and supervision. Regular ongoing contact with health providers will be necessary to ensure practices are consistent with current medical status.

20. Q: I was just told by a parolee on my caseload that he has AIDS, and that no one else knows. Who should I tell? Is there anything else I should do? Should he see a doctor?

A: Aside from discussing the case with the Senior Parole Officer or other appropriate Division staff, Parole Officers are precluded from revealing any individual's medical status to any other source without his written permission. While Part 24 of the State Sanitary Code provides for mandatory reporting of AIDS, reporting must be directly by the person identifying the condition (e.g., physician, lab, coroner) to the Commissioner of Health utilizing prescribed forms.

If the parolee is not seeing a doctor, the Parole Officer should help him locate a clinic and any other required medical support services. All parolees with AIDS should have plans in place for medical services, to insure these are available when needed. This plan should include having the parolee sign any release of information forms necessary to enable the Parole Officer to obtain medical status reports from any treating physician.

In a situation like this, one of the most important responses by the Parole Officer is to counsel the parolee about the seriousness of this medical condition and the importance of medical treatment and responsible behavior. The Parole Officer is in a critical position to provide direction to the parolee and will want to discuss with him the ways in which this illness may impact daily living. The Parole Officer will want to insure that the parolee is receiving necessary medical, financial and other related assistance and assist him towards this end.

21. Q: A parolee I supervise who has a history of IV drug use seems to be losing weight rapidly and complains of symptoms that sound like AIDS. I've directed him to see a doctor, and have even located a clinic that will see him, but he has resisted going. What alternatives do I have?

A: The steps described here are the appropriate ones to take, that is, to counsel the parolee to obtain medical treatment, to assist him by identifying community resources and to facilitate the process of obtaining these resources in every way possible (such as, contacting the clinic on behalf of the parolee or escorting him to the clinic).

It is important that we recognize resistance and denial as common reactions to life-threatening illness, reactions which often keep people from seeking needed medical treatment. These cases require patience and creativity to encourage the parolee to obtain the medical evaluation and assessment which seemed to be indicated. Ultimately, however, the Parole Officer has little recourse if the parolee refuses to seek medical treatment, even if AIDS is suspected. This disease is not classified as a communicable disease and is not quarantinable, nor is having AIDS a criminal activity. The Parole Officer's alternatives in this situation are to bring all resources to bear to encourage the parolee to seek the medical attention that seems to be indicated.

22. Q: A parolee I supervise who has AIDS has lost his residence and has no prospects for another. What can I do beside send him to a men's shelter?

A: A shelter, typically a congregate living situation with limited facilities for privacy or personal hygiene, is not an adequate or appropriate setting for individuals who are seriously ill or suseptible to infection and other communicable diseases. Shelter settings should be used only as temporary, last resort for parolees with AIDS, and intensive efforts to work with community resources to locate an appropriate residence should be a priority. Assistance in locating housing should be sought from the DOP AIDS Liaison or Parole Services Program Specialist before sending any parolee with AIDS to a men's shelter.

23. Q: Does the Division have money to help parolees with AIDS with the cost of housing or other expenses?

A: The Emergency Support Fund and Emergency Housing Funds established in each area office exist to assist parolees in need of housing, transportation and other assistance. Funds can be accessed in accordance with local area office procedures.

24. Q: The number of people exposed to AIDS seems to be increasing all the time, and a lot of parolees are at risk because of IV drug use. How do I protect myself in case a parolee I'm taking into custody has AIDS? What should I do if I am exposed to AIDS by a parolee who spits on me or bites me? What if I get stuck by a needle or cut by a razor while I'm searching someone?

A: Apprehending a parolee who has AIDS or ARC should be a well planned operation. Advance thought should be given to contingency plans in the event that any problems develop.

Extreme caution should be exercised when searching any releasee known or suspected to have a disease that can be transmitted by blood contact since hypodermic needles, knives, or other such objects capable of causing puncture wounds might be encountered.

Advance arrangements should be made with the institution that is expected to receive the releasee whenever possible. The location of hospitals in the area should be known in the event that medical treatment is needed for any parties involved.

At the conclusion of the operation the case record should be annotated to indicate what transpired. If any unusual event occurred or circumstances were encountered, an Unusual Incident Report should be prepared according to standing procedures.

25. Q: What special precautions should be taken when transporting a releasee who has AIDS or ARC?

A: Any time it is necessary to transport a releasee who has AIDS or ARC, the Parole Officer or Warrant Officer responsible for transporting the releasee should be informed that the individual has AIDS or ARC, just as they should be informed if an individual is suicidal, is epileptic, or had any other medical problem. Standard procedures should be followed in these cases as they would be with any other releasee being transported by staff.

26. Q: If I violate a parolee who is diagnosed as having AIDS or ARC, where do I take him once I have him in custody and what information can I share with the other law enforcement agency?

A: The Division has both a responsibility and a legal authority to advise local jurisdictions of a parolee's medical status, to the extent that such medical conditions may require special treatment or handling for the health and safety of the parolee, other inmates or Corrections staff.

Upon arrival at a local detention site, Parole Officers should advise Corrections staff of the parole violator's medical status in the same manner that a Parole Officer would provide information in the case of an individual suffering from a heart condition, diabetes, etc.

27. Q: What precautions should I take when collecting or testing urine samples from parolees? What should I do if I get splashed with urine?

A: Parole Officers should not collect urine samples from any parolee suspected or diagnosed as having AIDS. If urine testing is required in these cases, the parolee should be referred to a clinic for this purpose.

Under ordinary circumstances, disposable gloves and special clothing should be worn by anyone who takes urine specimens. It is also suggested to place the urine specimen cup inside a plastic bag in order to control spillage.

If for some reason an individual is splashed with urine, however, there is no reason for alarm as the HTLV III virus has not been isolated in urine and no cases of AIDS have ever been linked to urine. Soiled surfaces should be cleaned with disinfectants, such as household bleach (dilute one part bleach to ten parts water).

28. Q: Is protective clothing available if I should need it, and how do I get it?

A: Protective clothing (gowns, gloves and masks) have been made available to each area office. Area Supervisors are responsible for providing access to these garments.

29. Q: Shouldn't all parolees be required to be tested for AIDS?

A: The State of New York does not recommend or support mandatory HTLV-III antibody testing for any group or individual. The screening test indicates only the presence of antibodies to HTLV-III virus, not the presence of virus . The presence of antibodies in the blood means only that the person has been exposed to the virus at some time. It does not necessarily mean that the individual is carrying the virus and is capable of transmitting it to others. Most persons exposed to the HTLV-III virus will not develop AIDS.

For parolees who request it, testing can be obtained through regional HTLV-III antibody test sites that have been established by the State Health Department to provide testing and counseling for persons who wish to know if they have been exposed to the virus. Testing is free of charge at these sites, and strict confidentiality is maintained through use of a code system. Persons seeking the HTLV-III antibody test need not give a name, address or any other potentially identifying information. Private physicians also have been provided information about procedures for performing the test or arranging for their patients to obtain testing. For information on HTLV-III testing in New York City call (718) 485-8111; outside of New York City call (518) 473-0641.

30. Q: Should I be counseling parolees about safe sex and drug use as it relates to AIDS?

A: Counseling is an important part of a Parole Officer's job. Parolees who have a history of drug use may well be at risk of getting AIDS, and should be counseled about these issues. There are community resources available to you through the AIDS Task Forces to help you in this regard, either by providing direct counseling to parolees or by helping you to enhance your skills in this area.

31. Q: What resources are available within the Division to assist us and provide updated information on procedures related to inmates and parolees with AIDS?

A: Each region has designated an AIDS Liaison and a Parole Program Specialist who are available to provide technical assistance in difficult cases, and who are responsible for disseminating information about AIDS and resources programs available to assist people with AIDS. Lists of DOP Regional AIDS Liaisons and Parole Services Program Specialists are contained in Section VI of this manual; additional information about programs and resources can be found in Section V. This manual has been designed to be easily updated so new materials can be included as they are acquired.

## Prerelease Agreement - New York State Division of Parole and the Social Security Administration

This Prerelease Agreement should not be confused with the Pre-Release Centers and programs operated by the Department of Correctional Services.

### I. INTRODUCTION

The Social Security Administration (SSA) and the New York State Division of Parole (DOP) propose a Prerelease Agreement for inmates of State correctional facilities who are to be released to parole supervision. The difficulty of making suitable release arrangements for prisoners is exacerbated if the prisoner is suffering from a disability, particularly those suffering from AIDS. The purpose of the Prerelease Program is to provide a guarantee of financial help for those who are paroled to the community and to ensure that title XIX (Medicaid) eligibility is established as quickly as possible. Proper use of a prerelease procedure will facilitate release plan development and will ensure continuity of medical care upon release to the community.

Upon notification that a prisoner has been accepted for parole, or anticipation of a likely release decision by the Parole Board, the DOP will review the inmate's income, resources and disability for potential Supplemental Security Income (SSI) eligibility. SSA will provide the DOP with guidance in evaluating both medical and nonmedical criteria.

Those inmates whose income or resources exceed the SSI eligibility limits will be referred to the NYS Department of Social Services, Division of Medical Assistance for "Medicaid Only". Those inmates who appear to be SSI eligible will have an SSI application filed in accordance with the Prerelease Program procedures. In no case will a potential SSI applicant be considered for the program more than 90 days prior to the scheduled release date. This will allow social security sufficient lead time to make a medical determination prior to release.

This agreement is effective June 2, 1986.

NOTE: A liaison will be identified for each SSA District or Branch Office parallel to each institutional or area Parole Office for purposes of implementing this Prerelease Agreement.

## II. THE APPLICATION PROCESS

### A. New York State Division of Parole Responsibilities

The Parole Officer located at the correctional facility will identify prisoners who could benefit from the prerelease procedure according to the following guidelines:

1. The individual's release is imminent, i.e., could be released within 90 days.

2. The individual has a need for funds, i.e., meets the SSI income and resource limitation criteria.

3. The individual has a condition which can be considered as disabling under SSA's criteria.

Upon identification of an inmate who meets the basic criteria, the Parole Officer will prepare a packet to be forwarded to the parallel SSA district or branch office. The packet should contain the following completed forms:

1. SSA -3368 - Disability Report

2. SSA-3369 - Vocational Report - (Should not be completed if claimant never worked or had only one job in the 15-year period before he stopped working.)

3. (2) SSA-827s - Authorization to Release Medical Information to the Social Security Administration

4. SSA-8510 - Authorization to Obtain Personal Information

5. SSA-824 - Report on Individual with Mental Impairment (if applicable)

6. SSA-8000 - Application for Supplemental Security Income - (Completion of the SSI Application will vary according to prior agreement with the local social security office.)

Supplies of the above forms will be provided to the institutional parole offices for completion by Parole Officers. In addition, the Parole Officer should attach a copy of the New York State Department of Correctional Services Medical Discharge Summary Form or other summary of medical evidence. This will assist SSA in making disability determinations, especially presumptive disability determinations in certain cases.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Social Security Administration

Region II
Federal Building
26 Federal Plaza
New York NY 10278

## Medical Evidence Needed for Disability Claims For Persons with AIDS/ARC

Physicians who treat persons with AIDS or ARC may receive a request for a medical report in support of a patient's claim for Social Security or SSI disability benefits. Below is the type of evidence which should be included in the medical reports.

1. Medical History

Details of the medical history should include:

- Presenting symptoms.
- Pertinent physical findings at onset.
- Clinical course to the present.
- Where there has been significant weight loss, the number of pounds lost and representative weights should be given, plus the period of time over which the weight was lost.
- Relevant DATES should always be given. (The onset date of disability can affect the amount of retroactive benefits due.)

2. Current Symptoms

Current symptoms (e.g. fatigue, fevers, night sweats, anorexia, diarrhea, cough, shortness of breath) should be quantified, where possible, in terms of:

- Frequency
- Duration
- Precipitating factors
- Mode of relief

3. Current Physical Findings

- Both positive and negative relevant findings should be reported.
- Findings such as lymphadenopathy, nodules, plaques, lumps, rashes, thrush, bruises, bleeding, skin ulcers, etc. should be described in terms of location and extent.
- Where CNS involvement has resulted, the relevant reflex, motor, or sensory abnormalities should be given.
- Where retinal involvement has occurred, fundoscopic findings and current visual acuity (with best correction) are needed.
- Current height and weight should be given.

### 4. Laboratory Testing

These should include:

- Diagnostic tests showing immune deficiency

- Lymphocyte subpopulation studies
- Lymphocyte transformation studies (if available)
- CBC with differential (esp. WBC and Hematocrit)
- ANA

- Diagnostic tests showing opportunistic infection involved, e.g.:

- Pathology report
- Bronchoscopy
- Endoscopy
- Chest x-ray
- Stool analysis
- Culture reports
- CSF analysis
- Platelet count
- Liver function studies
- Kidney function studies
- GI series
- Skeletal survey
- ECG
- CAT scan

- You may include a copy of the laboratory's report or cite the pertinent findings. It is especially important to give the specific gross and microscopic examination findings from pathology reports.

- For patients with ARC, any relevant test results should be given.

- DATES of testing should always be given.

### 5. Treatment and Response, Prognosis

- Specify current mode of treatment and response.
- Give dosages for any medications.
- For patients with ARC, give prognosis for current episode of illness.

# APPENDIX E

## Educational Brochures, Posters and Cards

- *AIDS in the Black Community*
- *Informacion a las Parejas sobre AIDS/SIDA*
- *AIDS Kills Women and Babies*
- *Alcohol, Drugs & AIDS/Alcohol, Drogas y AIDS*
- *Buddy Program - San Mateo County, California AIDS Project*
- *AIDS & Your Job - Are There Risks?*
- *Has the AIDS Epidemic Affected Your Clients?*
- *Safer Sex Guidelines*

## WHO GETS AIDS?

Anyone can get AIDS if they are not careful when they are having sex with another person, or if they are shooting drugs and sharing or re-using needles. Children can be born with AIDS from their infected mother. Straights can get it as well as Gays and those who go "both ways."

If current trends continue, by 1991 — in the next five years — more than a quarter of a million people will have contracted full-blown AIDS in the United States. This will occur unless we change our sexual behavior and drug using habits.

While Blacks only make up 12% of the population in the United States, 25% of all persons with AIDS are Black persons. This means that so far, one out of every four persons who has AIDS in the United States is a Black person. This means that by 1991, **67,000 Blacks** could contract full-blown AIDS.

Six out of every ten children who have AIDS in the United States are Black children.

**AIDS IS FATAL**
**THERE IS NO CURE FOR AIDS**
**BUT AIDS CAN BE PREVENTED**

## BE CAREFUL DON'T BE RIDICULOUS

You cannot get AIDS from sitting on a toilet seat.

You cannot get AIDS from eating food prepared by someone who has AIDS.

You cannot get AIDS from holding, hugging, or touching a person who has AIDS.

You cannot get AIDS from working with, or attending school with someone who has AIDS.

**The way you get AIDS is by exchanging body fluids (basically blood and semen) with your sexual partner or drug using partner.**

### FOR MORE INFORMATION

Call or write to the National Coalition of Black Lesbians and Gays, 930 F Street, N.W., Washington, D.C. 20004. Telephone (202) ~~737-5276~~. 265-7117

This brochure was funded by the D.C. Commission of Public Health of the D.C. Department of Human Services.

Government of the District of Columbia
Marion Barry, Jr., Mayor

★ ★ ★

## AIDS IN THE BLACK COMMUNITY

## THE FACTS

ARIZONA STOP AIDS PROJECT
736 EAST FLYNN LANE
PHOENIX, ARIZONA 85014
602-277-1929

## WHAT IS AIDS?

AIDS is the final stage of a serious health condition caused by a virus that can be passed from one person to another during sexual contact and through the sharing of needles.

The virus which causes AIDS causes the body to lose its natural defenses against disease. The body then becomes weak and open to attack by several types of rare diseases that do not normally attack a healthy body. It is one of these diseases that eventually kills the person who has AIDS.

Not everyone infected with the AIDS virus gets AIDS. Some people remain healthy, while others get a less severe form of the disease. This less severe form is called ARC, which is short for AIDS-related complex.

If you are sexually active, you should assume that the virus can or may already have been passed on to you by a sexual partner, or that you can pass it on to him or her. *YOU SHOULD THEREFORE TAKE PRECAUTIONS.*

**PRACTICE "SAFER SEX"**

## DON'T GET AIDS

If you are **"In the Life,"** fool around sometimes, or are Gay, you should not allow semen to enter your body or your partner's body. *ALWAYS USE A CONDOM (RUBBER) DURING SEXUAL INTERCOURSE.*

If you are **straight** *ALWAYS USE A CONDOM (RUBBER) DURING SEXUAL INTERCOURSE.*

Avoid drugs, but if you shoot drugs, seek help, and by all means *DO NOT SHARE NEEDLES OR "WORKS."*

If you have been sexually active and plan to settle down and have kids, you may want to be tested to see if you or your spouse are carrying the AIDS virus. Check with the nearest AIDS-related agency or with your doctor for counseling.

Keep your body's defense system strong by eating nutritionally balanced meals and by not abusing any kind of drugs, including alcohol, marijuana, poppers, heroin, cocaine or PCP. Drugs weaken the body's defense system.

## WARNING SIGNS OF INFECTION WITH THE AIDS VIRUS:

- *Always feeling tired, light-headed, and headachy,* and this tiredness is not due to physical activity.
- *Suffering from unexplained weight loss* of more than ten pounds, which lasts more than a month.
- *Having diarrhea for a long period* with no clear reason.
- *Having fevers or night sweats* which last for several weeks.
- *Having swollen lymph glands (lumps)* either in the neck, armpits, or groin.
- *Having thrush,* which is a whitish coating on the tongue. This condition may be accompanied by a sore throat.
- *Having recently appearing or slowly enlarging purplish lumps* or blotches on top or beneath the skin or inside the mouth, anus, nose, or underneath the eyelids.
- *Having a heavy persistent or dry cough* that is not from smoking and that has lasted too long to be a cold or flu. Fever and shortness of breath may also be present.
- You may have these signs and not always have an AIDS virus infection. Always *check with a doctor* when you have any of the above signs.

*Recuerde*

## El AIDS/SIDA se puede prevenir

Sea usted o su compañero(a)/pareja corren riesgo de contagio, siga los consejos de este folleto y siempre use preservativos.

Nunca comparta las agujas.

Funding Provided by the
State of California
Department of Health Services

Para más información llame al San Francisco Aids Foundation Hotline:

| | |
|---|---|
| en San Francisco | 863-AIDS |
| en el norte de California (gratis) | 800-FOR-AIDS |
| TDD (sordo-mudos) | 415-864-6606 |

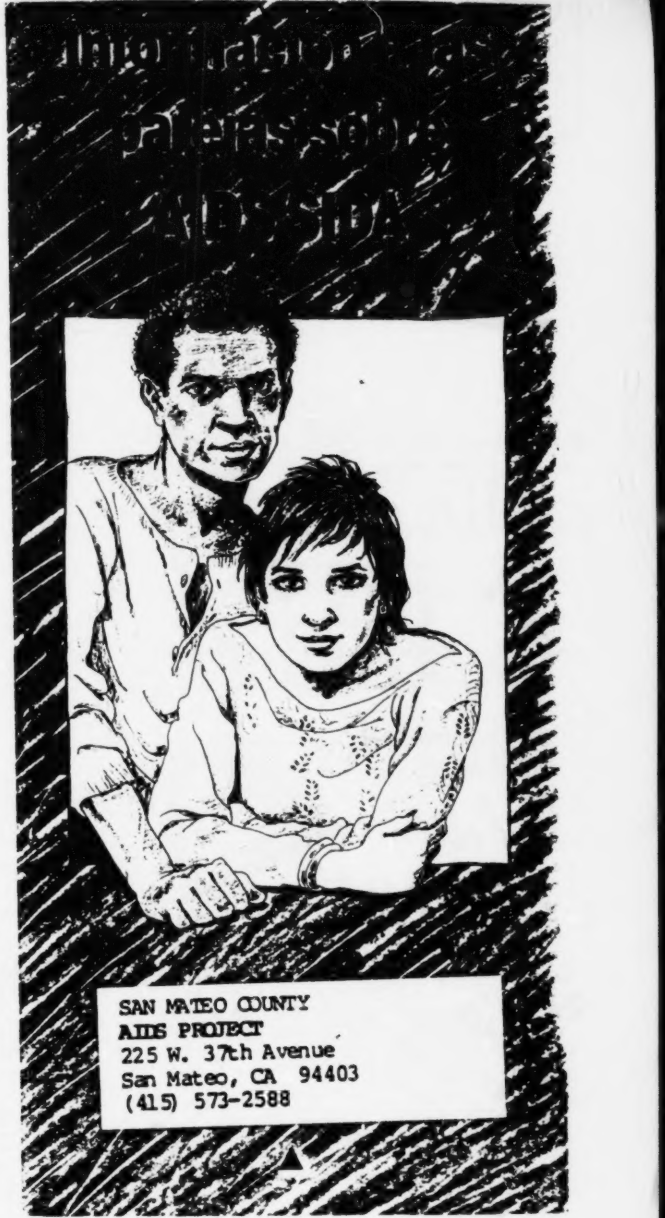
entre las 9 am y las 9 pm (hora del Pacífico) en días laborales y entre las 11 am y las 5 pm durante los fines de semana.

San Francisco AIDS Foundation
333 Valencia Street, 4th Floor
San Francisco, CA 94103

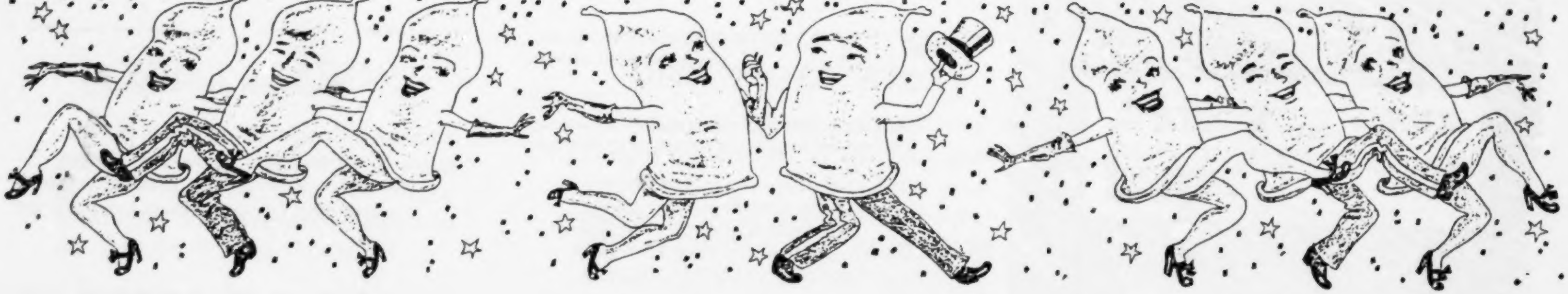
Parte de los fondos para este folleto fueron provistos por el Departamento de Salud Pública de la ciudad de San Francisco.

Marzo 1986

traducido por Miguel Telleria
tipografía por La Raza Graphics Center



SAN MATEO COUNTY
AIDS PROJECT
225 W. 37th Avenue
San Mateo, CA 94403
(415) 573-2588



**¿Qué es el AIDS (SIDA)?**

AIDS es el Síndrome de Immuno Deficiencia Adquirida. El virus llamado HIV produce el AIDS (SIDA).

El AIDS ha causado la muerte en todos los grupos sociales, principalmente de estos grupos:

> Mujeres y hombres que han tenido relaciones sexuales con personas de estos grupos
>
> Hombres y mujeres que usan agujas para drogarse
>
> Homosexuales y bisexuales
>
> Gente que ha recibido sangre que contiene el virus del AIDS
>
> Niños nacidos de padres que pertenecen a estos grupos

**¿Cómo se contrae el AIDS?**

La sangre y el semen son portadores del virus del AIDS. El fluido vaginal también puede llevar el virus del AIDS. La sangre y el semen tienen que ir directamente de una persona infectada a otra.

Al compartir agujas durante el uso de drogas, también contrae el virus.

Una mujer embarazada puede transmitir el virus a su bebe por nacer.

**Tu no puedes contagiarte con el AIDS** por:

Los besos: Besos en la piel son seguros. El virus

sabemos de alguien que haya contraído el AIDS por besos de boca a boca.

Tocándose: Tu no puedes contagiarte con el AIDS tocando a una persona con AIDS o estando cerca de ella.

Comer: Tu no puedes adquirir el AIDS comiendo con una persona con AIDS.

Estornudando, usando vestidos o usando la cama de una persona con AIDS.

**¿Cómo puedo saber si tengo el virus del AIDS?**

Tu puedes hacerte un examen de anticuerpo en que se muestre si eres portador del virus del AIDS. Algunas personas que tienen el virus, se enfermarán. Conversa con un doctor, una enfermera o anda a un centro de salud para averiguar más sobre el examen.

**¿Cómo puedo protegerme a mi mismo/a y a mi compañero/a?**

No se puede decir que alguien tiene el AIDS, por su aspecto externo. Sigue las siguientes instrucciones:

*Para sexo anal o vaginal:*

> Usa siempre un condón. Usa un condón y un espermicida. Los espermicidas matan el esperma en el semen. También matan el virus del AIDS en el semen. *NO USE* aceite vegetal, mineral ni vaselina con el condon.
>
> Sique las instrucciones del paquete del condón.
>
> ¡Asegúrate que el condón no se rompa!
>
> ¡No uses el condón más de una vez!

*Para sexo oral:*

> No dejes que entre el semen de un hombre infectado en tu boca.
>
> El fluido vaginal de una mujer infectada puede transmitir el virus.
>
> La sangre del flujo menstural también puede portar el virus.
>
> El sexo oral con una mujer infectada es de mayor riesgo cuando ella está con su período menstrual.

**TU PUEDES DETENER EL AIDS**

Sigue los consejos de este folleto.
Usa siempre condónes y no compartas agujas.

**Signs of AIDS:**

- Swollen glands
- Diarrhea
- Night sweats
- Dry cough
- Tired each day
- Fever
- Unexplained weight loss

**If you are worried about AIDS or feel sick, you can get help:**

**In Jail**

Contact the medical office or call Forensic AIDS Project: (415) 864-4589

**Out of Jail**

Call the AIDS Hotline.
In San Francisco: (415) 863-AIDS
In Northern California: (toll-free)
800-FOR-AIDS
TDD (for deaf people): (415) 864-6606

or call the Forensic AIDS Project:
(415) 864-4589

Partial funding for this brochure was provided by the San Francisco Department of Public Health and by the California Department of Health through the San Francisco Department of Public Health

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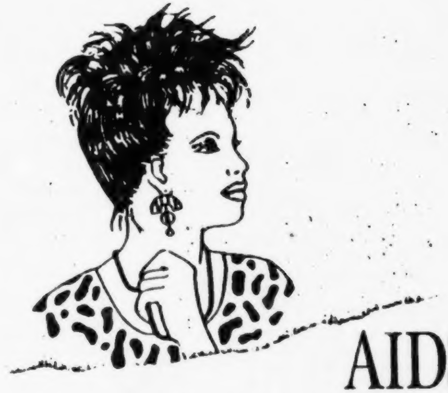
Design: Shelley Harper
Typography: La Raza Graphics Center

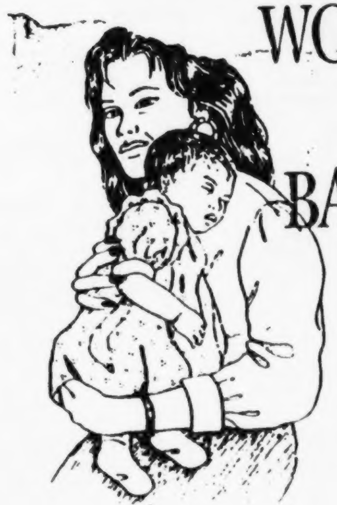
This brochure was prepared by the Forensic AIDS Project of the San Francisco Department of Public Health Jail Medical Services and produced by the San Francisco AIDS Foundation

SF AIDS FOUNDATION

San Francisco AIDS Foundation
333 Valencia Street
Fourth Floor
San Francisco, CA 94103

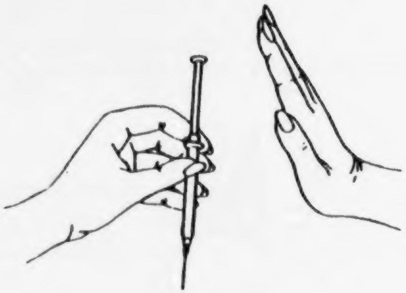


# AIDS KILLS WOMEN AND BABIES



**You can get AIDS from sex or sharing needles.**

**You can stop AIDS:**



Never share needles or works.

Always use a rubber (condom) when you have sex.

You can't tell who has AIDS by how they look. Someone can feel and look O.K. and still give AIDS to you if you have sex with them or share needles with them.

You can give AIDS to your unborn baby without knowing it. Get medical help right away if you are pregnant.

You can't get AIDS from touching, food, sneezes, toilet seats, clothes or sheets.

# ALCOHOL DRUGS & AIDS

## What's the Connection?

Drugs and alcohol are known to cause a variety of health problems. Recent research has indicated that alcohol, as well as such street drugs as amphetamines (speed), marijuana, and nitrite inhalants (poppers), all damage the immune system, leaving the user open to infection and cancer.

The reasons for the use of drugs and alcohol are as varied as the individuals who use them. Much of this drug use may have begun innocently but progressed to a point of harm, carrying with it many health risks.

Drugs and alcohol are believed by many researchers to be significant factors in increasing personal risk for AIDS:

- The cause of AIDS is a type of virus (called a retrovirus) which changes the structure of the cells it attacks. It may require the presence of an already damaged immune system before it can cause disease.
- Alcohol and drugs interfere with many types of medical and alternative therapies for AIDS.
- Alcohol and drugs alter the judgment of the user, who may become more prone to engage in activities which put people at high risk for AIDS.
- Alcohol and drug abuse causes stress, including sleep problems, which harms immune functioning.

The AIDS crisis has brought about a growing health awareness. For many people, this means re-evaluating their drug and alcohol use.

## Alcohol

Alcohol abuse is one of the leading health problems in the United States. Excessive drinking causes disease in every part of the body.

- Alcohol abuse decreases white blood cell counts, causing the body to respond poorly to infection.
- Alcoholic liver disease inhibits the body's ability to form T-cells (white blood cells affected by AIDS).
- Chronic abusers of alcohol have fewer T-cells.
- Alcohol abuse is a co-factor in the development of many forms of cancer.
- Chronic abusers of alcohol tend to have poor nutritional intake, leading to a generalized state of poor health.
- Alcohol abuse interferes with the body's use of vitamins and minerals necessary to maintain a healthy immune system.

## Amphetamines
## (Speed, Crank)

Amphetamine use can lead to numerous health problems. Using contaminated needles is a known risk factor for contracting AIDS. There is also risk of injecting foreign bodies into the blood stream which may cause damage or infection.

Use of amphetamines in any form, whether injected or not, can damage many body systems, including the immune system.

- Liver damage from amphetamine use causes an overall suppression of the white blood cell count, diminishing response to infection.
- Malnutrition due to appetite suppression deprives the body of essential vitamins and nutrients, causing a general decline in health.
- Amphetamine euphoria may lead to behavior generally accepted as increasing risk for contracting AIDS.

## Marijuana

Marijuana is a widely used drug, often believed to have few harmful effects. However, recent research has indicated that it may lower the body's ability to fight infection.

- One study has shown a decrease in antibodies circulating in the blood stream of frequent users.
- Another study of frequent users has found abnormalities in T-cells function closely resembling those found in AIDS.
- Impaired judgment may make the user more prone to engage in high risk sexual activities.

## Nitrites
## (Poppers, Amyl)

Poppers were one of the first factors considered as a possible cause of AIDS due to their widespread use as a new sexual stimulant in the gay community. The role played by this drug in AIDS has yet to be understood.

- Some researchers believe poppers may be a co-factor in the development of AIDS.
- There is strong evidence that poppers lead to generalized suppression of the immune system.
- Some research indicates that poppers may be a co-factor in the development of Kaposi's sarcoma.

## Other Drugs

Research into the effects on the immune system of drugs such as cocaine, heroin, Quaaludes, and many others is not yet available. This does not mean that these drugs are safe. Problems may stem from direct bodily harm from the drug or from impaired judgment.

## What To Do

*IF YOU . . . .*

- **Feel a loss of energy,**
- **Are under a great deal of stress,**
- **Develop infections easily,**
- **Eat poorly or have no appetite, or**
- **Fear that you might have AIDS**

*AND YOU DRINK OR USE DRUGS,*

- **Cut down or stop.**
- **Don't share needles.**
- **Learn to "get high" without drugs.**
- **Try to reduce stress. Techniques include meditation, exercise, hobbies, support groups, friendships.**
- **Eat well and get plenty of sleep.**
- **Follow "safe sex" guidelines.**
- **Know the signs and symptoms of AIDS.**
- **Get regular medical checkups.**
- **Seek professional help for drug and alcohol problems.**

For more information about AIDS and sensitive health care referrals, call the

**San Francisco AIDS Foundation Hotline**
**333 Valencia Street, 4th Floor**
**San Francisco, California 94103**
**(415) 863-AIDS**
**or**
**Northern California AIDS Hotline**
**1-800-FOR-AIDS**

Text by the Committee on Substance Abuse and AIDS, San Francisco, California
Translation by Lucrecia Bermudez
Production by San Francisco AIDS Foundation, and the Pacific Center AIDS Project.
Partial funding provided by San Francisco Department of Public Health and the California Department of Health Services through the San Francisco Department of Public Health.

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# ALCOHOL DROGAS Y AIDS

## ¿Cuál Es La Relación?

Es sabido que el alcohol y las drogas son la causa de una variedad de problemas de la salud Recientes estudios han indicado que el alcohol, al igual que otras drogas, como anfetaminas, marihuana e inhalantes de nitrito, todas dañan el sistema inmunológico, dejando al que usa estas drogas, propenso a infecciones y cáncer

Las razones para el uso de drogas y alcohol son tan variadas como los individuos que las usan. Mucho del uso de estas drogas puede que haya empezado inocentemente, pero aumentó a un punto de peligro, acarreando con ello muchos otros problemas de la salud.

Muchos investigadores creen que las drogas y el alcohol son factores significativos en el aumento del riesgo personal de contraer AIDS.

- La causa de AIDS es un tipo de virus (llamado retrovirus), el cual cambia la estructura de las células que ataca Puede que requiera la presencia de un sistema inmunológico ya dañado, antes que una enfermedad pueda iniciarse
- El alcohol y las drogas interfieren con muchos tipos de terapia, médica y alternativa, en el tratamiento de AIDS
- El alcohol y las drogas alteran el juicio del que las usa, pudiendo así comprometerse a participar en actividades que signifiquen el exponerse al alto riesgo de contraer AIDS.
- El abuso de alcohol y drogas causan alta tensión, incluyendo problemas al dormir, los cuales afectan el funcionamiento inmunológico

La crisis de AIDS ha producido un aumento de conciencia sobre la salud Para mucha gente esto significa la reevaluación de su uso de drogas y alcohol

## Alcohol

El abuso del alcohol es uno de los más graves problemas en los EE UU. El tomar excesivamente causa enfermedades en todo el cuerpo

- El abuso del alcohol disminuye el número de glóbulos blancos, causando una pobre respuesta a las infecciones
- Enfermedades en el hígado producidas por el alcohol, inhiben la habilidad del cuerpo para formar células T (glóbulos blancos afectados en AIDS).
- Los alcohólicos crónicos tienen pocas células T
- El abuso del alcohol es un co-factor en el desarrollo de muchas formas de cáncer
- Los que abusan del alcohol tienden a tener una nutrición pobre, llegando a un estado generalizado de mala salud
- El abuso del alcohol interfiere con el uso que el cuerpo hace de vitaminas y minerales, necesarios para mantener un sistema inmunológico saludable

## Anfetaminas

El uso de anfetaminas puede ocasionar nuevos problemas de salud El uso de agujas contaminadas es un conocido factor de riesgo para contraer AIDS. Existe, además, el riesgo de inyectar cuerpos extraños en la corriente sanguínea, lo cual puede causar daño o infección El uso de cualquier forma de anfetaminas, sea inyectada o no, puede dañar muchos sistemas del cuerpo, incluyendo el sistema inmunológico

- El hígado dañado por el uso de anfetaminas causa una supresión total del número de glóbulos blancos, disminuyendo la respuesta a la infección
- La malnutrición debida a la disminución del apetito, priva al cuerpo de las vitaminas y nutrientes escenciales, ocasionando un declive en la salud en general
- La euforia de la anfetamina puede provocar un cambio de conducta, generalmente aceptada como un incremento del riesgo de contraer AIDS

## Marihuana

La marihuana es una droga ampliamente usada, y se cree que tiene pocos efectos dañinos A pesar de ello, estudios recientes indican que la marihuana puede disminuir la habilidad del cuerpo para confrontar una infección

- Un estudio ha mostrado una disminución de los anticuerpos, que circulan en la corriente sanguínea de los consumidores de la droga
- Otro estudio de consumidores frecuentes, ha encontrado anormalidades en la función de células T, bastante parecidas a las encontradas en AIDS
- El desvirtuado juicio puede hacer que el consumidor esté más propenso a participar en actividades sexuales de alto riesgo

## Nitritos

Los "poppers" fueron uno de los primeros factores considerados como posible causa de AIDS, debido a su uso generalizado como estimulante sexual en la comunidad homosexual El rol que esta droga juega en AIDS tiene aún que ser entendido.

- Algunos investigadores creen que los "poppers" pueden ser un co-factor en el desarrollo de AIDS.
- Hay una fuerte evidencia que los "poppers" generan una supresión total del sistema inmunológico
- Algunos estudios indican que los "poppers" pueden ser un co-factor en el desarrollo de sarcoma Kaposi

## Otras Drogas

Estudios sobre los efectos, en el sistema inmunológico, de ciertas drogas como cocaína, heroína, Qualudes y otras muchas, no están aún disponibles Esto no significa que estas drogas no sean un peligro Hay problemas que pueden provenir directamente del cuerpo afectado por drogas o juicio desvirtuado

## Lo Que Se Puede Hacer Si tú

- **Sientes la pérdida de energía.**
- **Estas bajo una gran tensión.**
- **Desarrollas infecciones fácilmente.**
- **Comes muy poco o no tienes apetito.**
- **Temes haber adquirido AIDS**

**Y BEBES O CONSUMES DROGAS**

- **Consume menos estas sustancias o deja de hacerlo.**
- **No uses agujas.**
- **Aprende a "elevarte" sin drogas.**
- **Trata de reducir la tensión. Las técnicas incluyen meditación, ejercicio, distracción, grupo de apoyo y amistades.**
- **Come bien y duerme bastante.**
- **Sigue las guías para un "sexo seguro."**
- **Conoce los signos y síntomas de AIDS.**
- **Ten chequeos médicos regulares.**
- **Busca ayuda profesional para los problemas de drogadicción y alcoholismo.**

Para mayor información acerca de AIDS, **llama a la Línea de Emergencia de la Fundación AIDS en San Francisco.**

**333 Valencia Street, 4th Floor**
**San Francisco, California 94103**
**(415) 863-AIDS**

**en el Norte de California**
**1-800-FOR-AIDS**
**libre de recargo**

Texto del comité de Abuso de Substancias/AIDS,
San Francisco, California
Traducido por Lucrecia Bermúdez
Producido por San Francisco AIDS Foundation
Pacific Center AIDS Project
Subvencido parcialmento por el Departamento de la Salud Pública de San Francisco y el Departamento de los Servicios de Salud de California por medio del Departamento de la Salud de San Francisco

● *July 1986*

BUDDY

SAN AIDS MATEO

# AIDS PROJECT

County of San Mateo
Department of Health Services
225 W. 37th Avenue
San Mateo, CA 94403

**San Mateo County AIDS Project**
Department of Health Services
225 W. 37th Avenue
San Mateo, CA 94403

**ELLIPSE**
631 Woodside Road
Redwood City, CA 94061

ELLIPSE

The Buddy Program is coordinated by Bill Glenn. Initial training, continued education and ongoing professional support are provided by the County of San Mateo. Buddies is a program of ELLIPSE: Peninsula AIDS Services Inc.

For further information call:
San Mateo County AIDS Project
(415) 573-2588
or
ELLIPSE: Peninsula AIDS Services
(415) 366-AIDS

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## APPLICATION FORM

If you are interested in becoming a buddy or you are a person with AIDS or ARC who is interested in having a buddy, please fill out this form and mail it to ELLIPSE: Peninsula AIDS Services, 631 Woodside Road, Redwood City, CA 94061.

Name ____________________ Home Phone ____________

Address ____________________ Day Phone ____________

(Street)

____________________

(City)

☐ I am interested in becoming a buddy.

☐ I am interested in having a buddy.

## BUDDIES RESPOND TO A NEED:

AIDS is a community problem. The number of people affected by AIDS has been increasing dramatically in the last five years. It is projected that by 1991, there will be over 220,000 cases of AIDS in the United States. San Mateo County is expected to share proportionately in this increase. In addition, for every person with AIDS there are seven to ten people with ARC (AIDS Related Complex). It would be difficult to estimate in any realistic way the vast numbers of people who are now, or by 1991 will be, infected by the AIDS virus.

In our county, as in other areas of the world, many people with AIDS and ARC have experienced rejection, depression, and even ostracism due to their infection. Therefore, the need for both emotional and practical support on a personal one-to-one basis must be met. The Buddies Program is San Mateo County's response to these needs.

## WHAT IS A BUDDY?

A buddy is a trained resource and support person for people with AIDS (PWA) and AIDS Related Complex (ARC) and their families and friends. A buddy's goal is to establish a relationship and create an environment which is conducive to meeting the complex needs of PWAs and ARCs.

## WHAT IS A BUDDY'S TIME COMMITMENT?

A buddy's assignment is to a PWA or ARC, and, upon request, some buddies may be assigned to their families and friends. The program requires a six month commitment; however, the major commitment is to the assigned person. Therefore, a buddy will be expected to continue with the PWA until they no longer need a buddy. On a weekly basis, this must include at least one contact. Depending on the PWAs' needs and state of illness, it could range from fifteen minutes to several hours a day. Volunteers must also attend bi-weekly support group meetings with other buddies.

## HOW TO HANDLE ETHICAL QUESTIONS?

A buddy's relationship with a PWA/ARC is one of privilege and power. Issues concerning money, power of attorney, intimate relationships, and conservatorship must be referred to the leadership of the Buddies Program.

## WHAT ABOUT SUBSTANCE ABUSE?

PWAs and ARCs with alcohol and drug problems will be supported in obtaining treatment for these problems prior to joining the Buddies Program. Buddies will provide education and support in order to help people with AIDS and ARC understand the relationship between substance abuse and their health problems.

## WHAT ABOUT CONFIDENTIALITY?

In becoming a volunteer, a buddy has agreed to keep all information concerning a PWA/ARC, their family and friends, strictly confidential.

## HOW IS A BUDDY TRAINED?

Currently, San Mateo County has an expanding group of trained buddies, who are giving support to people with AIDS and ARC, and their significant others on a daily basis. All buddies have participated in an intensive 36 hour training program. Facilitators are experts in the field of AIDS. Course content includes:

- Updated information on the medical aspects of AIDS
- Family issues and AIDS
- Special concerns of women and AIDS
- Nutritional needs of people with AIDS
- Safe sex guidelines
- Basic nursing techniques
- Techniques in imagery, relaxation and massage
- Strategies of conflict resolution
- Death and dying
- Suicide and AIDS
- Legal issues for PWAs
- Funeral planning
- In-depth guide to resources for PWAs in San Mateo County
- Messages of hope from PWAs and their buddies

Participation in the program is limited. All volunteers are interviewed and screened by the training staff to discover their most useful contribution to the program.

### A buddy to a person with AIDS:

- LISTENS
- encourages a positive, hopeful attit towards life
- keeps in touch by telephone
- makes home and hospital visits
- involves PWA in community activities
- assists with household chores (laundry, shopping, cleaning, gardening, etc.)
- helps meet nutritional needs (grocery shopping and meal preparation)
- provides transportation when necessary (to scheduled appointments)
- helps maintain family rituals and holidays
- helps PWA live and die with dignity

### A buddy is *not:*

- a trained therapist, and may not provide therapy
- a medically trained person, and may not prescribe specific treatments or diagnose ailments
- a lawyer, and may not offer legal advise

However, a buddy will be able to access services and make appropriate referrals when the need arises. More importantly, a buddy will know when to ask for consultation from the Buddy Program leadership.

# AIDS and Your Job—Are There Risks?

American
Red Cross

U.S. Public
Health Service

AIDS (acquired immune deficiency syndrome) is a frightening disease, but no one should be afraid of catching it at work.

AIDS is caused by a virus* that does not survive well outside the body. The virus is *not* spread by casual, nonsexual contact. This means that you can't catch AIDS from a cough, a sneeze, a handshake, or a hug. Nor can you catch it from the food you eat, no matter who prepared or served that food. You won't get AIDS by working closely with a coworker who has the disease. Nor will you get it by having coffee, going to lunch, or sharing toilet facilities with that person.

Careful studies have shown that doctors, nurses, and medical technicians who have taken care of AIDS patients have not contracted the disease from them. Scientists have not found a single instance in which the AIDS virus has been spread through ordinary nonsexual contact in a family, work, or social setting.

AIDS, in fact, is a very hard disease to catch. Yet recent surveys have shown that almost one third of the American population believes AIDS can be spread by casual contact, in spite of all scientific evidence to the contrary. Fear of the unknown may help to explain why some people react in this way, since people tend to fear what they do not understand. The purpose of this brochure is to give you facts about AIDS—facts that can save you needless worry about catching AIDS from coworkers.

## *If AIDS Is Not Spread by Casual Contact, How Does It Spread?*

The two main ways the AIDS virus is spread are sexual contact and sharing of contaminated needles and syringes among users of illegal intravenous (IV) drugs. The virus can also be passed on from infected mothers to their babies during pregnancy, at birth, or shortly after birth (probably through breast milk).

In a small number of cases, the virus has been

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**The virus that causes AIDS and related disorders has several different names: HTLV-III, LAV, ARV, and most recently HIV. In this brochure, it is called "the AIDS virus."*

spread through blood transfusions and through blood products (clotting factors) used to treat patients with hemophilia and other blood clotting disorders. But today the chances that anyone will get AIDS in this way are extremely small, for these reasons:

- Blood collection centers screen donors carefully to prevent people at risk for AIDS from donating blood.
- All donated blood is now tested for antibody to the AIDS virus. (Antibodies are substances produced in the blood to fight disease organisms.) When donated blood tests positive for the AIDS antibody, it is discarded; it never enters the blood supply.
- Clotting factor products are now heated or treated chemically to destroy the virus.

About 98 percent of all AIDS cases reported in this country to date have occurred in the following groups of people:

- Sexually active homosexual and bisexual men (or men who have had sex with another man since 1977) (65 percent)
- Present or past users of illegal IV drugs (17 percent)
- Homosexual and bisexual men who are also IV drug abusers (8 percent)
- Persons who have had transfusions with blood or blood products (2 percent)
- Persons with hemophilia or other blood clotting disorders who have received clotting factor products (1 percent)
- Heterosexual men and women (these include sex partners of persons with AIDS or at risk for AIDS, and people born in countries where spread of the virus by heterosexual sex is thought to be more common than in the United States) (4 percent)
- Infants born to mothers infected with the AIDS virus (1 percent)

About 2 percent of AIDS patients do not fall into any of these groups, but scientists believe that the virus was spread to them in similar ways. Some patients could not be followed up, or died before complete medical histories could be taken.

## *The AIDS Virus and Its Effects*

AIDS was first reported in the United States in 1981. By September 1986, the Public Health Service had received reports of more than 24,000 people with AIDS, 54 percent of whom had died. No one has recovered from the disease.

The virus that causes AIDS damages the body's natural immune defenses against disease and can also infect cells in the brain. People who have AIDS develop unusual, life-threatening illnesses that do not affect people with normal immune systems. It is the appearance of these unusual illnesses that makes possible the diagnosis of AIDS. Two of the illnesses most often seen in AIDS patients are *Pneumocystis carinii* pneumonia (a parasitic infection of the lungs) and Kaposi's sarcoma (a rare type of cancer), although patients may develop other kinds of cancers and infections as well.

Infection with the AIDS virus does not always lead to AIDS itself. Some infected persons have developed a condition that scientists call "AIDS-related complex" (ARC). Symptoms of ARC include fatigue, fever, loss of appetite and weight, diarrhea, night sweats, and swollen lymph nodes in the neck, armpits, or groin. Anyone with one or more of these symptoms for more than two weeks should see a doctor.

Public Health Service scientists estimate that 1 to 1½ million Americans—in addition to those known to have AIDS—have been infected by the AIDS virus and carry it in their bodies. Many of these persons show no signs of illness and do not know they carry the virus; however, they can spread it to others in the ways that have already been explained. The Public Health Service has urged persons at high risk for infection by the AIDS virus (see box) to consider taking the test for the AIDS antibody so that, if the test is positive, they can take appropriate action to prevent further spread of the virus.

A positive result on the antibody test does *not* mean that a person has AIDS or will necessarily go on to develop either AIDS or AIDS-related illnesses. It does mean that the person has been infected by the virus and may be capable of transmitting it throughout his or her lifetime.

Information about where to get the AIDS antibody test is available from private physicians, health clinics, and state and local health departments.

## AIDS and Your Job

Again, it should be emphasized that a fellow employee who has AIDS or who carries the AIDS virus does not pose a danger to you. Remember, the virus is not spread in the air you breathe or the food you eat; nor is it spread by routine, nonsexual, everyday contact.

For workers in general, then, there is no need for worry or special precautions. Following are guidelines and answers to some questions that may arise for workers in particular occupations.

## Food Handlers

Because the AIDS virus is not transmitted in food, people who work with food, such as cooks, caterers, waiters, bartenders, airline attendants, and others, should not be restricted from work because they have AIDS or have been infected by the AIDS virus.

*All* food service workers, including those with AIDS, should, of course, observe good personal hygiene and sanitary food-handling procedures. They should take particular care to avoid injury to their hands while preparing food.

Sanitation guidelines require that any food that becomes contaminated with blood from a cut be thrown away. Food service workers with AIDS or AIDS virus infection should be restricted from work if they have open sores or skin lesions or illnesses for which any other food handler would also be restricted.

## Personal Service Workers

Beauticians, barbers, cosmetologists, electrologists, manicurists, and similar personal service workers routinely observe procedures that protect them and their clients from bacterial and viral infections. The risk of spreading the AIDS virus in these settings is very low, but when instruments that could draw blood are used, sterilizing equipment is important.

- Instruments that penetrate the skin, such as ear-piercing devices and needles used for electrolysis, tattooing, and acupuncture, should be discarded after one use, or thoroughly cleaned and disinfected between uses with a chemical germicide.
- The same procedure should be followed for other instruments, such as razors or cuticle scissors.
- A personal service worker with open sores or weeping sores should refrain from direct client contact until the wound is healed.

All instruments used by personal service workers should be sterilized or disinfected between uses. Information on commercial germicides may be obtained from the Disinfectant Branch, Office of Pesticides, Environmental Protection Agency, 401 M St., S.W., Washington, DC 20460.

## Workers With Jobs Requiring Special Precautions

Police personnel, firefighters, emergency medical workers, and prison employees may be exposed to blood or other body fluids of people with AIDS or AIDS-related disorders because of accidents, fires, or violence. Fortunately, by observing a few simple rules, workers can avoid infection.

- Avoid wounds from weapons and punctures from hypodermic needles used by drug abusers. Blood on these articles could cause infection.
- Use disposable gloves in handling contaminated articles.
- Place contaminated articles in a cut-proof evidence bag to be taken to a laboratory for examination or disposal.
- Clean up blood spills promptly with freshly diluted household bleach—one part bleach to 10 parts water.
- If mouth-to-mouth resuscitation is necessary for a person with AIDS, use an "S-tube" or a hand-operated resuscitator bag.

- Wash your hands after exposure to any possible source of infection. Hand washing reduces the chance of spread of infection.
- Wear protective masks, gloves, gowns, and shoe coverings, if there is a chance of exposure to blood or other body fluids of someone with AIDS.

## *For More Information...*

***More information about AIDS and AIDS-related illnesses can be obtained from—***

- Your union representative or personnel department.
- Your doctor.
- Your state or local health department.
- The Public Health Service's toll-free hotline: 1-800-342-AIDS.
- Your local chapter of the American Red Cross.

### Persons at Increased Risk of Infection by the AIDS Virus

Persons in the following groups are at increased risk of infection by the AIDS virus:

- Homosexual and bisexual men (or men who have had sex with another man since 1977)
- People who inject illegal intravenous drugs or who have done so in the past
- Persons with symptoms of AIDS or AIDS-related illnesses
- Persons from Haiti and Central African countries, where heterosexual transmission is thought to be more common than in the United States
- Male or female prostitutes and their sex partners
- Sex partners of persons infected with the AIDS virus or at increased risk of infection
- Persons with hemophilia who have received clotting factor products
- Infants of high-risk or infected mothers

AIDS-20
Oct 1986

# HAS THE AIDS EPIDEMIC AFFECTED YOUR CLIENTS?

A support and information sharing group is available for people with AIDS and people with AIDS-Related Complex. This group meets every Tuesday afternoon from 2 - 4 pm at 736 East Flynn Lane (1 block south of Glendale, 1 block east of 7th Street).

A group is also available for those who have tested positive or are concerned about AIDS (the worried well). This group meets every Sunday afternoon from 4 - 6 pm at 4450 North 12th Street, Suite 126 (12th Street and Campbell).

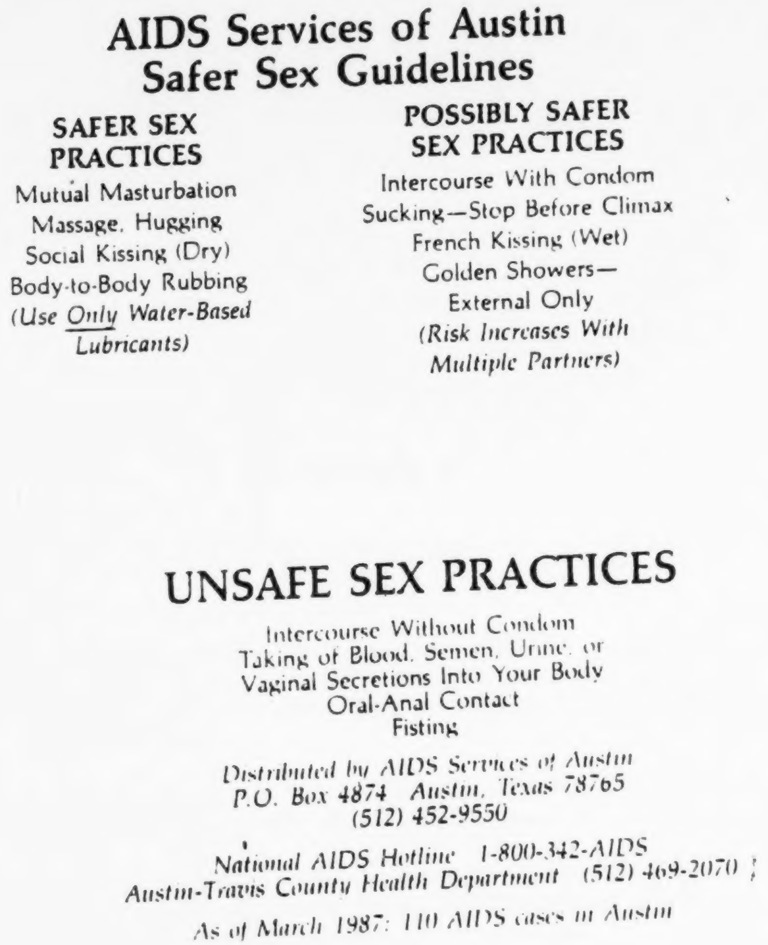
A third group is available for family, friends, and significant others of people with AIDS or AIDS-Related Complex. This group meets every Wednesday evening from 7 - 9 pm at St. Joseph's Hospital, 350 West Thomas Road, Dining Room H.

These groups are conducted by professionals and are offered at no charge.

For further information, please call:

Arizona Stop AIDS Project

**277-1929**



# AIDS Services of Austin
# Safer Sex Guidelines

## SAFER SEX PRACTICES

Mutual Masturbation
Massage, Hugging
Social Kissing (Dry)
Body-to-Body Rubbing
*(Use Only Water-Based Lubricants)*

## POSSIBLY SAFER SEX PRACTICES

Intercourse With Condom
Sucking—Stop Before Climax
French Kissing (Wet)
Golden Showers—External Only
*(Risk Increases With Multiple Partners)*

## UNSAFE SEX PRACTICES

Intercourse Without Condom
Taking of Blood, Semen, Urine, or Vaginal Secretions Into Your Body
Oral-Anal Contact
Fisting

*Distributed by AIDS Services of Austin*
*P.O. Box 4874 Austin, Texas 78765*
*(512) 452-9550*

*National AIDS Hotline 1-800-342-AIDS*
*Austin-Travis County Health Department (512) 469-2070*

*As of March 1987: 110 AIDS cases in Austin*

# APPENDIX F

## Federal Policies

- *Committee on Criminal Law and Probation Administration of the Judicial Conference of the United States, Guidelines for U.S. Probation officers and U.S. Pretrial Services Officers*
- *Parole Commission Instructions to Probation Officers on Supervision of HIV-Positive Parolees*
- *Recommendations to the Presidential Commission on the HIV Epidemic by the Executive Committee of the American Probation and Parole Association*

COMMITTEE ON CRIMINAL LAW AND PROBATION ADMINISTRATION
OF THE
JUDICIAL CONFERENCE OF THE UNITED STATES
19613 UNITED STATES COURTHOUSE
601 MARKET STREET
PHILADELPHIA, PA 19106

JUDGE EDWARD R. BECKER
CHAIRMAN

8-597-9642 (FTS)
215-597-9642 (COMM.)

September 30, 1988

MEMORANDUM TO ALL: JUDGES, UNITED STATES DISTRICT COURTS
UNITED STATES PROBATION OFFICERS
UNITED STATES PRETRIAL SERVICES OFFICERS

FROM: Judge Edward Becker, Chairman
Judicial Conference Committee on Criminal Law
and Probation Administration

SUBJECT: Guidelines for U.S. Probation Officers and U.S. Pretrial Services Officers Supervising Clients Who Have Been Exposed to the Human Immunodeficiency Virus (HIV) or Who Have Acquired Immune Deficiency Syndrome (AIDS)

The information and guidelines contained in this memorandum have been developed by the Committee on Criminal Law and Probation Administration for the use of probation and pretrial services officers who are supervising individuals on probation and pretrial supervision who are known to have tested positive for antibody exposure to the Human Immunodeficiency Virus (HIV) or who have developed symptomatic HIV disease, including Acquired Immune Deficiency Syndrome (AIDS). HIV infection refers to the condition of individuals who are known to have been exposed to the virus and are asymptomatic or who have symptomatic HIV disease. AIDS is the most serious form of the HIV disease. This proposal is intended to provide guidance in preventing the transmission of HIV within the community as well as protecting the confidentiality of exposed individuals. It is crucial for probation and pretrial services offices in each district to learn the State laws which govern the use of HIV tests and the disclosure of their results. State statutes also address civil and criminal penalties which attach to violation of confidentiality requirements. The proposed guidelines should be implemented in a manner consistent with State law.

United States Probation Officers and United States Pretrial Services Officers should take the following actions in the supervision of individuals on probation, on bond supervision, or under investigation who have been exposed to HIV or who have developed symptomatic HIV infection, including AIDS.

1. Officers, in consultation with the resource person (see Paragraph 9), should evaluate the individual and develop a case plan, keeping in mind education, counseling and treatment components necessary for a successful adjustment in the community. The

Office of the General Counsel in the Administrative Office has undertaken to write to the Surgeon General and the Association of State and Territorial Health Officials requesting information on locally available resources for utilization by probation offices. The information will be communicated to Chief District Judges and Chief Probation and Pretrial Services Officers as soon as it is available.

COMMENT

> This provision is consistent with § 2.38-04(a) of the Parole Commission instructions and with what is normally required of a probation officer.

2. Individuals under supervision with HIV infection, including those who have developed AIDS, should not be managed differently than any other supervisee unless medically indicated on the basis of symptoms or coexisting infections.

COMMENT

> Officers have raised the concern that they might manage a client with HIV infection differently from another client. For example, an officer may avoid personal contact with the client and rely heavily on telephone contact. This type of practice is not acceptable.

3. The supervisee should be instructed of the importance of self-disclosure of HIV infection to prospective sexual/drug partners. The individual should be advised he or she may be subject to certain civil or criminal liabilities for the transmission of HIV to another person.

COMMENT

> This provision is consistent with § 2.38-04(c) of the Parole Commission instructions. People have been held civilly liable in some States for infecting a person with herpes. The analysis for HIV should be the same. Some States have also proposed and/or passed criminal statutes making it a criminal offense for a person to knowingly expose someone to the HIV virus. For example, see Nev. Rev. Stat. § 201.358 (prostitute who knowingly exposes one to HIV is guilty of a felony), Fla. Stat. § 384.24, and Idaho Code §§ 39-601, 39-607. Additionally, a bill has been introduced in Congress to make it a Federal crime to knowingly infect someone with HIV (H.R. 4289).

4. Officers should not disclose HIV infection or illness information to the supervisee's family members, parents or sexual/drug partners without the supervisee's informed, written consent. If the supervisee will not consent to disclosure, and State law permits non-consensual disclosure to public health officials, the probation officer should notify

public health officials. Notification of other third parties is the responsibility of the exposed person. Partner notification programs conducted by public health agencies encourage patient and physician responsibility for third-party notification and in many States assume the burden for confidentiality and ensuring notification by trained disease control specialists.

## COMMENT

This provision is at variance with § 2.38-04(g) of the Parole Commission instructions in that it does not permit an officer to make a "discrete and confidential warning" of a supervisee's HIV infection unless the supervisee gives his informed, written consent. The Parole Commission instructions recognize the moral obligation to make a disclosure that a probation officer might feel and the possibility that some States might impose a legal duty on the officer to make a disclosure. This provision attempts to balance these concerns with other competing concerns.

Placing a disclosure requirement as a condition of supervision would be difficult for the probation service to enforce. This provision reflects the position that HIV infection is a public health concern and disclosure should be handled by public health officials and the exposed individual.

Public health concerns, about confidentiality have led many States to pass confidentiality laws that appear to prohibit third-party disclosure without an informed, written consent and impose civil and criminal penalties for violating the law. See, e.g., Wis. Stats. § 146.025, Cal. Health and Safety Code § 199.21 (Deering 1988).

Although this provision emphasizes that any third-party disclosure of HIV infection should be consensual, it does permit non-consensual disclosure to public health officials if permitted by State law. This exception recognizes the fact that some States require HIV antibody positivity reporting to public health officials and place the burden of any additional third-party disclosure on the public health officials. See, e.g., Colo. Rev. Stat. §§ 25-4-1401 to 25-4-1409, Nev. Rev. Stat. §§ 441.110 to 441.320.

This provision also recognizes the concern that some States might arguably impose a duty on an officer to make a third-party disclosure. This concern is drawn from the line of cases which have imposed liability on psychotherapists who fail to warn potential victims of a patient's violent intent. See, e.g., Tarasoff v. Regents of Univ. of California, 551 P.2d 334 (Cal. 1976). This concern is also based on the fact that some

States have made it a crime to knowingly spread AIDS and Congress is considering making this a Federal crime.

To date the Committee is not aware of any jurisdiction which has imposed an affirmative duty on a probation officer to make third-party disclosures. In fact, some jurisdictions whose precedent suggests that such a duty might be imposed have actually prohibited non-consensual third-party disclosure. See, e.g., Tarasoff, 551 P.2d at 334 and Cal. Health and Safety Code § 199.21. But, see also Cal. Health and Safety Code § 199.25, which permits a physician to make a non-consensual disclosure to the spouse of a patient with HIV infection. In addition, some States which impose criminal liability for knowingly spreading HIV infection also impose civil and criminal penalties for making a non-consensual disclosure that an individual has HIV or AIDS. See Fla. Stat. § 384.24 and § 384.29, Idaho Code § 39-601 and § 39-606.

In summary, it seems impossible to devise a uniform procedure regarding third-party warnings that respects State public health laws because of the variations in State laws. For the reasons articulated in this comment, the Committee believes that on balance a policy of limited disclosure is advisable. However, as the law in this area evolves, this provision may need to be reconsidered. Moreover, the importance of assessing and following State law in this area cannot be stressed enough.

5. In all cases, the officer should first attempt to have the supervisee give informed, written consent authorizing the release of information about HIV infection to the U.S. Marshal, residential facilities, halfway houses and jails. In the absence of such written consent, this information should be disclosed to the U.S. Marshal when a violator's warrant is issued and to the health care provider and/or supervisor of the halfway house or jail facility when the supervisee is placed in their custody.

## COMMENT

This provision is consistent with § 2,38-04(h) of the Parole Commission's instructions and reflects the concern that arresting officers and custodial officers should be aware of the potential risk of exposure to HIV infection. It also assists the custodial officers in responding to any medical needs of individuals in their custody.

6. When information concerning an individual's HIV antibody test result or information concerning a diagnosis of HIV infection is disclosed to the officer by a third party or by the client, the officer should seek the written, informed consent of the client before

making further disclosure. In preparing the consent form, attempts should be made to obtain an authorization to disclose to those individuals who have a legitimate need to know, such as sexual/drug partners, public health officials, health care and drug treatment providers, custodial officers, and the court.

The attached consent form could be used for this purpose. When an informed, written consent is obtained, information concerning an individual's diagnosis of AIDS, positive test results for HIV, and signed consent forms, should be reported in the case record, but should be kept in an envelope in a portion of the file marked "Confidential Information." Pretrial diversion reports, postsentencing reports and any other social history investigations contained in the client's case file which contain such confidential medical information should also be placed in the envelope marked "Confidential Information." Re-disclosure of test results or an individual's medical condition should not be made without specific additional consent by the supervisee.

Confidential record information should be treated like other medical record information and may be shared with other staff who are associated with the client and have a legitimate, professional need to know.

### COMMENT

> Given the uncertainty of the confidentiality requirements in each State, it is advisable that the officer always first seek the written, informed consent of the client before disclosing HIV positive test results or an AIDS diagnosis in order to avoid exposure to civil and criminal liability. It appears that in some States any disclosure is prohibited without the written, informed consent of the infected person. Intra-office disclosure should be limited to those individuals who have direct supervisory responsibility. A supervisee's HIV or AIDS condition should not become the subject of idle talk.

7. Information regarding defendants with HIV infection should not be disclosed in pretrial services reports or in presentence reports without the defendant's written, informed consent unless it is relevant to the offense charged, such as a sexual assault. However, the court may require the officer to disclose all known medical information about the defendant in order to determine its relevancy in the disposition of the case. In this situation, the officer should advise the court, confidentially, pursuant to the provisions of Fed. R. Crim. P. 32(c)(3)(A), of the individual's positive HIV test results and current symptomatic status and of the defendant's refusal to give consent for disclosure of this information.

### COMMENT

> This reflects the position of several members of the Committee who believe it would always be essential for the court to know all medical information about a defendant, including HIV infection information, prior to imposing

sentence. At the same time, this position attempts to protect the confidentiality rights of the individual.

8. Printed education materials on communicable diseases and infection control precautions, in general, as well as specific emphasis on HIV infection should be made available to all supervisees in office waiting rooms and given to officers for distribution and discussion with clients and their families. Staff may use appropriate locally available written materials from community HIV and AIDS testing and counseling sites. Officers should identify available local resources, which may include medical, social, and psychological services for people with HIV infection and local public health agencies, and should assist their clients in gaining access to such services upon request.

## COMMENTS

This provision emphasizes HIV infection education and awareness. Because the confidentiality laws of many States might prohibit an officer from disclosing to third parties that a client has HIV infection, this provision establishes a broad educational approach to alert all supervisees and their families to the facts and risks of HIV infection.

9. Each probation and pretrial services office should identify and designate an officer as an HIV resource person. That individual will participate in regional training activities concerning HIV infection and will gain a good understanding of information related to HIV infection. This resource person should be available to all staff within the district as a consultant on HIV infection and related issues. Officers should consult this resource person whenever they encounter a case situation involving HIV or AIDS. The resource person should become an expert in State confidentiality laws and should provide the office with periodic updates on the current state of the law.

## COMMENT

It appears that many States are passing legislation to address the requirements for disclosing to others that a person has HIV positive test results or symptomatic HIV disease or AIDS. Because the State requirements are not uniform and are still developing, it is advisable for each office to keep apprised of the relevant law. Additionally, scientific understanding and the treatment of HIV infection is always advancing. Officers should be aware of the latest information when discussing HIV and AIDS with clients. (See also Paragraph 1)

U. S. PROBATION

## CONFIDENTIAL INFORMATION RELEASE AUTHORIZATION

**Individual Who Is Subject Of Record**

Name

Address

City, State, Zip Code

| | |
|---|---|
| Identifying Number | Date of Birth |

Name & Address Of Agency Or Organization Being Authorized To Release Information

**Information May Be Released To**

Name

Organization

Address

City, State, Zip Code

Specific Records Authorized for Release (Include dates of records, if applicable)

Purpose or Need for Release of Information (Be specific)

I understand that I may revoke this authorization, in writing, at any time except where information has already been released as a result of this authorization. Unless revoked, this authorization will remain in effect until the expiration time I have indicated and initialed below.

_____ Authorization expires as of________________________________.(Date)
_____ Authorization expires _______ month(s) from the date I sign this authorization.
_____ Authorization expires after the following action takes place:

As evidenced by my signature below, I hereby authorize disclosure of records to the person(s) or agency(s) as specified above.

| | | |
|---|---|---|
| Signature of Individual Who is Subject of Record | | Date |
| Signature of Other Person Legally Authorized to Consent to Disclosure (If applicable) | Title or Relationship to Individual Who is Subject of Record | Date |

## §2.38-04 Supervision of HIV-Positive Parolees

In the case of a parolee who has been identified as infected with the Human Immunodeficiency Virus (HIV), the probation office for the district of supervision shall take the following steps:

(a) Evaluate the parolee immediately upon release to develop a case plan with education, counseling, and (where appropriate) treatment components.

(b) Explain to the parolee the methods of HIV transmission and the measures for preventing such transmission.

(c) Instruct the parolee that it is important for him to make disclosure of his HIV infection to prospective sex partners and other persons in danger of becoming infected by him. Inform the parolee that he may be subject to civil or criminal liability for transmission of HIV to another person.

(d) In a manner consistent with state confidentiality laws, refer the parolee (1) to resources for medical treatment and (2) to state or local health departments, self-help agencies or other community organizations and networks who provide counseling to persons with AIDS or AIDS-related conditions.

(e) To the extent permitted by state law, notify the appropriate state or local health department that the parolee is HIV-positive.

(f) If the probation office is aware of any specific person who is exposed to a medically recognized type of risk of infection from the parolee and believes that such person has not been notified of such risk, consult with the parolee's physician; health care provider; and, if necessary, with the state or local health authorities to determine if they are able and willing to provide a third party warning to such person.

(g) If such a warning is not prohibited by state law and if the parolee's physician, health care provider, and state and local health authorities are unable or unwilling to make such a warning, make a discrete and confidential warning of the parolee's condition to the person at risk and advise that person of one or more health professionals or organizations who can provide counseling.

(h) If a violator warrant is issued, notify the United States Marshal that the parolee is HIV-positive.

# RECOMMENDATIONS TO THE PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC BY THE EXECUTIVE COMMITTEE OF THE AMERICAN PROBATION AND PAROLE ASSOCIATION

## RECOMMENDATIONS

1. **The National Institute of Corrections** and the **Bureau of Justice Assistance** are to fund the American Probation and Parole Association to develop and deliver an **AIDS ISSUES IN PROBATION AND PAROLE curriculum** (based upon the research completed by Abt Associates for the National Institute of Justice) including training on the applicability of risk and needs assessment and Client Management Classification (unique probation and parole assessment instruments) in the supervision of persons with AIDS. Where applicable, the curriculum developed by the National Sheriff's Association should be utilized in order to reduce any duplication.

2. The **Department of Health and Human Services** is to establish and market a **network of health specialists** to deliver live training to the 50,000 probation and parole officers nationwide concerning the nature, prevention, transmission, and treatment for AIDS and the benefits of voluntary testing for HIV. This training is intended to enable probation and parole officers to provide education to the 2.5 million offenders under their supervision.

3. The **National Institute of Drug Abuse** is to conduct research to determine the number of intravenous drug users on probation or parole who have ARC or AIDS. Based upon the outcome of this research, NIDA is to encourage the Single State Drug Abuse Authorities to dedicate sufficient **treatment slots** to provide services to the portion of these people for whom services are appropriate and needed.

4. The **Bureau of Justice Assistance** is to develop a Program Brief for **Specialized Caseloads for Persons with AIDS** and include this program for funding under the Justice Assistance Act.

5. The **National Institute of Corrections** is to continue to fund the National Institute of Sentencing Alternatives to deliver **training on AIDS issues for Residential Community Corrections managers**.

6. The **Bureau of Justice Statistics** is to commence a **data collection process on probation and parole offender characteristics** (including estimates on the number of IV drug users on probation and parole) and the programs of supervision in operation (including those which provide services to offenders who engage in high risk activities). These data are to be included in the Bureau's STATISTICAL ANNUAL REPORT. Coordination with the National Institute of Drug Abuse should take place concerning seroprevalence data.

7. Policy for **routine or mandatory HIV testing of probationers or parolees are not to be encouraged or endorsed**. Testing is not controlling. Testing can divert funds which are needed for education. Testing can result in a false sense of security for those engaging in high risk behaviors. The benefits of voluntary testing with associated counseling should be marketed.

# APPENDIX G

## State Policies

- *Georgia Board of Pardons and Paroles*
- *State of New York Division of Probation and Correctional Alternatives (pp. 3-5, 14-16, 102-108)*

## GEORGIA BOARD OF PARDONS AND PAROLES

# POLICY FOR THE HUMAN IMMUNODEFICIENCY VIRUS INFECTED

1) The Board of Pardons and Paroles will not discriminate in the exercise of its powers and authorities against persons under its jurisdiction who have been diagnosed as infected with the Human Immunodeficiency Virus, where the HIV-infected individual has demonstrated to the Board or its representative a thorough awareness of the nature of the infection, the potential for transmission to others, a sincere commitment to a course of personal conduct which maximally endeavors to prevent any risk of transmission of the infection to others, a personal history lending credence to the foregoing, and a release or supervision plan which adequately comprehends appropriate measures for medical supervision, and assistance in the home or dwelling place.

2) The Board of Pardons and Paroles will not implement any form of release from confinement of an HIV-infected individual who has been discerned to be unable or unprepared to meet the criteria set out in the preceding policy statement.

3) The Board of Pardons and Paroles will impose special conditions for parole which are promotive of the well-being of the HIV-infected individual, his family or co-residents, and the general public. Special conditions are subject to amendment from time to time in order best to reflect current medical and epidemiological knowledge.

4) The Board of Pardons and Paroles, including its employees throughout the State, will not require an HIV-infected individual to disclose his medical condition to an employer or prospective employer, except in cases where the nature of the employment is such as to pose a real and immediate potential for injury to the person of the HIV-infected individual. Ordinarily, it will be deemed inappropriate for HIV-infected individuals to seek employment in a high risk industrial position. Employment in the construction industry is not deemed to be high risk employment for the purposes of this policy statement.

5) The Board of Pardons and Paroles will be furnished quarterly by its Director of Field Operations, a report which summarizes each case of an HIV-infected individual granted release pursuant to the Board's Policy for the Human Immunodeficiency Virus Infected, in order to monitor the state of each such individual, and facts deriving from their return to the general community.

6) The Board of Pardons and Paroles will expeditiously be informed by its field personnel in the event any HIV-infected individual under parole supervision ceases to meet the criteria set out in Statement 1 of this policy. Upon receipt of such notice, the Board will act to promote the health of the general public.

7) The Board of Pardons and Paroles will inform its employees throughout the State of this policy, and subsequent revisions, if any, through the Director of Central Operations and the Director of Field Operations.

8) The Board of Pardons and Paroles will, in any case where an individual affected by this policy has made application for out-of-state parole supervision, inform the prospective receiving state parole agency of the individual's medical condition. The Board will require an unequivocal statement, in all cases where it has received a request to provide supervision to a person paroled by another state, as to whether the prospective parolee has, or has not, been diagnosed as an HIV-infected individual. In all cases where the prospective parolee from out of state is disclosed to have been diagnosed as an HIV-infected individual, no acceptance for supervision will occur unless the individual meets the criteria set out in Statement 1 of this policy.

9) The Board of Pardons and Paroles will be informed by its Director of Legal Services whenever a medical or legal development occurs which may necessitate review or modification of this policy.

10) The Board of Pardons and Paroles will be informed by its Director of Legal Services whenever a medical or legal development occurs which may necessitate review or modification of this policy.

TO: Board

FROM: ______________________________ SS#

RE: Inmates name and number

TPM: Discharge Date:

Recommendation:

Relevant Prior Offenses (sex and/or Violent Offenses):

Date of Interview:

Medical Status: (HIV+) (ARC) (AIDS) - Include mental health status:

Drug Abuse History:

Institutional Conduct:

Parole Plan:

Remarks:

Recommendation:

# SPECIAL CONDITIONS OF PAROLE
# FOR
# HIV-INFECTED PAROLEES

1. I shall demonstrate through oral or written examination that I have been educated regarding my medical condition and its implications in my life. I understand the correct procedure for disposal or cleansing of physical objects soiled with my body wastes or fluids of any type. I accept my moral and ethical duties to others as well as myself in refraining from activities which could spread the disease as defined by accepted and current medical authorities.

2. I will permit the disclosure of my medical condition to those with whom I will reside. I will be given the opportunity to notify these individuals in a timely manner; however, if I fail to do so, the Parole Board will assume this responsibility.

3. I will have regular medical examinations by a physician who is aware of my medical condition. My physician will notify my parole officer in writing if my condition becomes such that I am not capable of working or if there are any other medical limitations which restrict my participation in the work place. I agree to sign a release of information form that will allow my parole officer access to any medical information concerning my condition during the period I am on parole.

4. I will not engage in sexual practices which have been identified by accepted medical sources as unsafe sexual practices for persons with HIV-infection. I shall disclose my medical condition to any person who is to be my sexual partner.

5. I will not donate or sell blood, plasma or organs under any circumstances.

6. I will cooperate with my mental health or counseling service which has been recommended for me by my parole officer.

7. I will cooperate with public health officials who monitor HIV-infection cases in Georgia.

8. I will refrain from excessive use of alcohol and all unprescribed controlled substances, and from the use of prescribed drugs except as recommended by my doctor.

9. I will refrain from IV needle use, unless prescribed by my doctor. I will safely dispose of any used needle or syringe.

10. I will refrain from any tattoo ing activity.

1/13/87

STATE OF GEORGIA

COUNTY OF ________________

## ACKNOWLEDGEMENT OF SPECIAL CONDITIONS OF PAROLE

I, the undersigned ________________________________, hereby declare that I have been provided with a copy of the Special Conditions of Parole for the HIV-Infected. Each Special Condition has been read by me, and I acknowledge that I fully understand each one of the Special Conditions. I agree to obey each Special Condition, and I clearly understand that my parole will be revoked, and I will be returned to prison, if I disobey any of the Special Conditions. I declare that I do desire to accept parole subject to the conditions listed on the parole certificate plus the Special Conditions of Parole for the HIV-Infected. I understand that the Special Conditions of Parole for the HIV-Infected have been given to me as a separate document in order to protect my privacy. I know that I am obligated to obey all of the Special Conditions, and my signature on this form expresses my awareness of the Special Conditions, and my promise to obey all of the Special Conditions.

This _____ day of _______________, 198 ___.

______________________________________

SUBJECT

______________________________________

WITNESS

1/13/87

# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

The undersigned, ________________________________, expressly hereby authorizes the release and disclosure without reservation of all health or medical documents, records, opinion, or information concerning the undersigned which are possessed or controlled by any individual or entity which has provided or is providing the undersigned with health care services of any kind of type, which may be requested by the undersigned or the State Board of Pardons and Paroles, its agents, or employees.

The undersigned declares hereby that no health records, documents information, reports, or matters of any type are to be withheld by any party furnishing health care services of any description to the undersigned, when such are requested by the undersigned or any person acting in behalf of the State Board of Pardons and Paroles. The undersigned will save harmless all persons who comply with this authorization.

The physician providing health care or medical services or examination to the undersigned is authorized hereby to state in writing for delivery to the undersigned or the State Board of Pardons and Paroles, whether the undersigned is capable of working, and which, if any, medical limitations govern the undersigned's participation in the workplace.

The undersigned expressly hereby acknowledges and consents that information obtained pursuant to this authorization may or will be used by the State Board of Pardons and Paroles for all purposes necessary to confirm the health status of the undersigned, the employment capabilities and status of the undersigned, and the compliance of the undersigned with the terms and conditions of the parole or other form of clemency granted to the undersigned by the State Board of Pardons and Paroles.

A photostatic copy of this authorization shall be considered to be a duplicate original, and shall be as effective and valid for all purposes as the original.

This ______________ day of ______________, 19____.

________________________________
SUBJECT

________________________________
WITNESS

1/13/87

STATE OF NEW YORK
DIVISION OF PROBATION AND CORRECTIONAL ALTERNATIVES
60 SOUTH PEARL STREET
ALBANY, NEW YORK 12207

# AIDS POLICY GUIDELINES FOR PROBATION DEPARTMENTS AND ALTERNATIVES PROGRAMS

*Mario M. Cuomo*
*Governor*

*Edmund B. Wutzer*
*State Director*

*Alice Green, Ph.D.*
*Deputy Director*
*Bureau of Planning, Policy,*
*and Information*

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## 1. THE PRE-SENTENCE INVESTIGATION REPORT

### Statement

If a defendant states that he or she has AIDS or ARC or if this information is transmitted to the investigating probation officer by another source, this should be reflected in the portion of the pre-sentence report that covers physical and mental condition. The source of the information and the circumstances under which it was obtained should be described and an assessment made of its reliability.

### Discussion

If a defendant has AIDS or ARC, this should be stated in the pre-sentence report. The information could be used by the judge as a factor in the sentencing decision. Moreover, if a defendant with AIDS or ARC is sentenced to prison, information about his or her illness would be essential for classification and medical treatment decisions.

The investigating probation officer, even in the absence of substantiation from the defendant or other persons, may strongly suspect that a defendant has AIDS or ARC. In these cases, the probation officer should indicate to the defendant why it is important, if the defendant does have AIDS or ARC, for this information to be included in the pre-sentence report.

## 2. CONFIDENTIALITY

### Statement

In general, staff of probation departments and alternatives programs should not divulge information to an employer or other third party concerning the serious illness (including AIDS or ARC) of a client, without the client's express written permission.

### Discussion

Case records and verbal information provided by clients of probation departments or alternatives agencies are confidential; access to this information is limited to those authorized by law or court order. Unauthorized disclosure of such records or information could damage the reputation of an agency or the credibility of its staff. In addition, if a client discloses to staff the speculation that he or she has contracted AIDS or ARC and this information is divulged to a third party when, in fact, the client does not have AIDS or ARC, staff may be liable to defamatory laws or for the invasion of privacy.

It is unlikely that a probation officer or staff member of an alternatives program would be liable for failure to disclose to an employer that a client is afflicted with AIDS or ARC. Since AIDS is not transmitted through casual contacts, an employer could not argue that the client was a threat to the health or safety of others in the work environment.

Probation officers and alternatives program staff should attempt to persuade clients with AIDS or ARC to reveal their illness to their spouse or other sexual partner(s). They should strongly urge such clients, and any other probationers in high-risk groups, to adhere to safe sex practices.

## 7. THE RULES OF SUPERVISION

### Statement

If a probationer has received a diagnosis of AIDS, ARC, or another serious disease, the general rules of supervision still apply. If there are mitigating medical circumstances, the supervision level and/or method for making personal contacts should be reevaluated.

### Discussion

Persons with AIDS or ARC may experience alternating periods of severe debility or illness, which may require hospitalization, and periods of relative recuperation. The medical circumstances of the individual should be taken into consideration when determining how the personal contact requirements will be carried out.

During periods of severe illness, an office visit could further weaken a probationer with AIDS or ARC and endanger his or her health. For those who are relatively well, on the other hand, an office visit could allow the probation officer to verify that required services are being obtained and that the client is not suffering discrimination because of his or her disability.

Level I cases require at least one home visit a month. Home visits may also be a method for making personal contacts with probationers in lower supervision levels. There is no evidence that AIDS or ARC can be transmitted through the type of casual contacts that would occur between a probationer and his or her probation officer in the home. In a major study conducted by Montefiore Medical Center in New York City, in 101 households that included an AIDS victim, only one family member (a five-year-old who most likely became infected in the womb or during childbirth) tested positive for HIV. AIDS is a very difficult disease to catch. Even health care workers who work with AIDS patients have not been shown to be at greater risk for getting AIDS on the job. Transmission factors for adults are limited to sexual contact, sharing needles and other intravenous drug paraphenalia, and blood transfusions with infected blood. It is now unlikely that anyone would get AIDS from blood donated after March 1985 when testing of all donated blood was begun.

The classification of a probationer should be reviewed quarterly and may be revised on the basis of this reassessment. AIDS may be a factor to be considered in the reclassification decision. However, 9 NYCRR §351.6(3) requires all level I cases to remain in that classification category for at least ninety days.

## 8. EARLY DISCHARGE

### Statement

A probation officer shall not recommend early discharge for any probationer solely because the probationer has AIDS or ARC or is a potential carrier of the HIV virus.

### Discussion

Section 410.90 of the Criminal Procedure Law governs termination of a probation sentence. To recommend early discharge solely because a probationer has AIDS or ARC or is a potential carrier of HIV infection would not be consistent with the criteria established in the law. Early discharge should only be considered when the probationer has diligently complied with the terms and conditions of the sentence, termination would not jeopardize public safety, and the probationer is no longer in need of guidance, training, or other assistance administered through probation supervision.

# AIDS: LEGAL QUESTIONS AND ANSWERS

The purpose of this Appendix is to assist local probation departments in clarifying questions surrounding the AIDS issue which relate to their activities and to provide general background information on the subject.

1. Q. WHAT, IF ANY, NEW YORK STATE LAWS EXIST WHICH PROHIBIT DISCRIMINATION OF AIDS VICTIMS OR POTENTIAL AIDS VICTIMS?

   A. Article 15 of the Executive Law, commonly referred to as the Human Rights Law, prohibits discrimination on the basis of age, race, creed, color, national origin, sex, disability or marital status. Section 296 of the Executive Law bars discriminatory practices in employment, places of public accommodation, resort or amusement, educational institutions, in public services, in housing accommodations, in commercial space, and in credit transactions.

   The high risk categories for AIDS have been considered to be homosexuals, bisexual men, intravenous drug users, and Haitians. Although recent medical findings remove Haitians as a category, discrimination on the basis of national origin would apply to Haitians. Subdivision 21 of Section 292 of the Executive Law defines disability. By definition, it would include intravenous drug users. In *People v. 49 W. 12th Street Tenants Corp*. (NY Sup. Ct. 1983), the Supreme Court held that AIDS is a physical disability and since it is a disability, the Human Rights Law would apply to AIDS victims and individuals perceived by others as being at risk for AIDS. Therefore, discrimination on the basis of sexual preference would also be prohibited.

   In Executive Order No. 28, Governor Mario Cuomo bars sexual orientation discrimination by State agencies or departments. Discrimination is prohibited in any matter pertaining to employment including, but not limited to, hiring, job appointment, promotion, tenure, recruitment and compensation.

   The Office of Employee Relations has been directed to promulgate guidelines prohibiting discrimination based on sexual orientation and to ensure swift and thorough investigations of complaints of discrimination based on sexual orientation with due regard for confidentiality.

2. Q. SHOULD THE REPORT ITSELF AND THE PRE-SENTENCE INVESTIGATION CONTAIN INFORMATION AS TO WHETHER THE INDIVIDUAL, THE DEFENDANT, IS HOMOSEXUAL, BISEXUAL, AN INTRAVENOUS DRUG USER OR HAS AIDS?

   A. Section 390.30 of the Criminal Procedure Law requires that the pre-sentence investigation consist of gathering of information with respect to the defendant's social history, family situation and personal habits. The investigation must include the defendant's physical and mental condition when available.

In the course of an investigation, information as to a defendant's intravenous drug use, diagnosis of having AIDS, ARC, or being a carrier should be included in the report since it relates to physical condition. A defendant's sexual preference could be construed as personal habits and/or family situation, which are routinely gathered in the course of an investigation. Its relevancy in all reports is questionable.

The extent of detailing personal habits and information on family in these reports is subjective. A probation officer must use his/her professional judgement and evaluate on a case by case basis whether the investigation should include information as to the defendant's sexual preference.

3. Q. IS A PROBATION OFFICER PROHIBITED FROM ROUTINELY QUESTIONING DEFENDANTS AND/OR PROBATIONERS ON THEIR SEXUAL PREFERENCE, INTRAVENOUS DRUG USE, AND WHETHER THEY HAVE AIDS OR ARE A CARRIER?

A. While questioning is not barred, it is nevertheless highly personal and sensitive in nature and therefore, it is not recommended that routine questioning take place. A probation officer must use his/her professional expertise and common sense as to soliciting responses on personal information. Should a defendant or probationer volunteer this information, further questioning would not appear inappropriate. If a probation officer has contact with any of the high risk categories, he/she should consider providing information (i.e., brochure, hot line number, testing sites) and encourage such individuals to seek counseling and testing.

4. Q. DOES STATE LAW OR REGULATIONS REQUIRE REPORTING OF AIDS OR SUSPECTED CASES?

A. No state law exists relative to reporting of these cases. New York State's Department of Health has promulgated a regulation which has the force and effect of law, 10 NYCRR Section 24-1.1, which requires all cases or suspected cases to be reported to the Commissioner of Health by city, county and district health officers, physicians, hospital administrators, laboratories, or persons in charge of State institutions. Pathologists, coroners, medical examiners or other persons who have determined from examination or from history of events leading to death, that the deceased was apparently affected with AIDS also must report to the Commissioner. In light of this regulation, a probation officer or probation department has no legal responsibility or duty to report AIDS or a suspected case.

5. Q. DOES A PROBATION OFFICER HAVE A LEGAL DUTY TO REPORT INFORMATION AS TO AIDS OR ARC TO A PROBATIONER'S EMPLOYER OR THIRD PERSON?

A. A probation officer is under no statutory or regulatory duty to report such information to a probationer's employer or third party. While a probation officer may face potential liability for failure to disclose such information, it is doubtful that such a lawsuit would be successful. Since AIDS or ARC is not contagious via casual contact, an employer could not argue that he/she, employees, or any customers' health or safety are at risk. As for a lawsuit brought by a spouse and/or anyone else that a defendant has had sexual relations with, an aggrieved party would have to establish that he/she has AIDS or is a carrier, and that failure to disclose directly resulted in contraction of the disease. Because the incubation period for AIDS is unknown, it would be hard to link a probation officer's non-action with liability. To date, no court has held that a third party has a duty to disclose an AIDS diagnosis to a spouse or sexual partner of an individual.

6. Q. **WHEN INFORMATION HAS BEEN VOLUNTARILY DIVULGED THAT A DEFENDANT HAS AIDS, CAN THE PROBATION OFFICER LEGALLY DIVULGE THIS INFORMATION TO A THIRD PERSON OR AN EMPLOYER?**

A. State law governing confidentiality of pre-sentence reports and memoranda, Section 390.50 of the Criminal Procedure Law, along with the Division of Probation and Correctional Alternatives' regulations in the areas of investigation and reports, case record management, and supervision (9 NYCRR 350.1(c), 348.4(k), and 351.8(d)) dictates confidentiality. Accessibility is limited only to those authorized by law or with a court order. To divulge reports or their contents would be in contravention of these confidentiality protections. State law further prohibits disclosure of medical records or information without a patient's consent. Any person disclosing such records or revealing medical information without an effective release form would be violating a patient's protected rights.

If the defendant divulges to the probation officer the speculation that he/she has contracted AIDS and the probation officer divulges this information to a third person, when in fact the defendant does not have AIDS, the probation officer may face a tort lawsuit for slander and/or invasion of the right of privacy.

7. Q. **DOES A YOUTH NEED HIS OR HER PARENTS' OR GUARDIAN'S CONSENT TO UNDERGO HIV ANTIBODY TESTING ?**

A. Section 2504 of the Public Health Law establishes that any person eighteen years of age or older may give effective consent for medical services for himself/herself and the consent of no other person shall be necessary. Although certain exceptions exist wherein parental consent for someone under eighteen is not necessary, for example emergency or pregnancy situations, it would appear that AIDS does not fall within the present acceptable exceptions.

Any youth who suspects he/she has contracted AIDS should be encouraged to reveal such suspicions to their parents or guardians and seek appropriate medical services.

8. Q. IN THE COURSE OF AN INVESTIGATION, SHOULD A PROBATION OFFICER REQUIRE THAT A DEFENDANT UNDERGO AN HIV ANTIBODY TEST?

A. No. Requiring that a defendant submit to such a test would be in contravention of constitutional protection against unreasonable search and seizure.

The State of New York does not recommend or support mandatory HIV antibody testing for any group or individual. The screening test indicates only the presence of antibodies to HIV, not the presence of virus. The presence of antibodies in the blood means only that the person has been exposed to the virus at some point in time. Most persons exposed to the virus will not develop AIDS.

9. Q. WOULD A CONDITION THAT A PROBATIONER MUST SUBMIT TO AN HIV ANTIBODY TEST BE LEGAL?

A. It would appear that such a condition would not be constitutional. Section 65.10(k) of the Penal Law establishes that any other permissible probation condition be reasonably related to a defendant's rehabilitation. Since testing and its results are unrelated to a probationer's rehabilitation, the condition would not be legal.

10. Q. ARE TESTING RESULTS KEPT CONFIDENTIAL?

A. The test sites established by the State Health Department maintain strict confidentiality through use of a code system. Persons seeking the HIV antibody test need not give a name, address, or any other potentially identifying information.

11. Q. IS AIDS TESTING MANDATORY FOR INMATES AND IS IT CONSTITUTIONAL TO SEGREGATE AIDS SUFFERERS IN PRISON?

A. AIDS testing is not routinely carried out in correctional institutions. In LaRocca v. Dalsheim (467 NYS 2d 302, 120 Misc. 2d 697 (1983)), the Supreme Court in Dutchess County did not uphold mandatory testing of the entire incarcerated population, but rather directed that the population be educated about AIDS. The court further held that the State acted reasonably in segregating prisoners known to have been afflicted with AIDS to reduce potential threat or spread of AIDS. In a federal case, Cordero v. Coughlin III 607 F. Supp. 9 (1984), which involved a suit brought by inmates who were complaining of being segregated, the court held that segregation was not a violation of their constitutional rights.

12. Q. CAN A PROBATION OFFICER REFUSE TO SUPERVISE A PROBATIONER WITH AIDS OR ARC, A HOMOSEXUAL PROBATIONER, A BISEXUAL, OR AN INTRAVENOUS DRUG USER, BECAUSE THEY ARE A POTENTIAL AIDS CARRIER?

A. Since AIDS or ARC cannot be contracted through casual contact, such a refusal would be unjustified. AIDS cannot be transmitted through sneezing, coughing, eating or drinking from the same utensils, or merely being around an infected person for any length of time. A refusal to supervise could likely subject an officer to disciplinary proceedings and may lead to allegations of unlawful discriminatory practices lodged against the officer and local probation department.

13. Q. IF A PROBATIONER HAS AIDS OR ARC, IS IT A LEGITIMATE REASON TO RECLASSIFY THE PROBATIONER TO A LESSER SUPERVISION CATEGORY?

A. The fact that a probationer has AIDS or ARC is not sufficient reason by itself to consider reclassification. The Division's regulation in the area of supervision, specifically 9 NYCRR §351.6(3), requires that classification of each probationer be reviewed quarterly by the probation officer or supervisor. Level of supervision may be revised by utilization of a reclassification process. Any case assigned to Level I must remain in that classification category for a minimum ninety day period.

14. Q. CAN A SUPERVISING PROBATION OFFICER REDUCE THE NUMBER OF REQUIRED PERSONAL CONTACTS IF A PROBATIONER HAS AIDS?

A. No. The Division's regulation in the area of supervision establishes minimum contact requirements based upon classification level. These requirements must be maintained. However, the physical condition of any probationer with a serious illness should be considered and taken into account if location or frequency of personal contacts must be altered.

15. Q. MAY AN EMPLOYER QUESTION AN APPLICANT AS TO HIS/HER SEXUAL PREFERENCE?

A. On 11/18/83, Governor Cuomo issued Executive Order No. 28. This order prohibits discrimination against individuals on the basis of sexual orientation or presumed sexual orientation in any matter pertaining to employment or services by the state, including but not limited to hiring, job appointment, promotion, tenure, recruitment, and compensation. It applies to all state agencies or departments. Since local probation departments are reimbursed by the State, they are required to comply with this order. In any case, employment discrimination due to sexual preference or perceived preference would be in violation of the Human Rights Law. Therefore, questioning an applicant as to his/her sexual preference is prohibited.

16. Q. WHAT HEALTH LAWS AND REGULATIONS EXIST RELATING TO AIDS?

A. Article 27-E of the Public Health Law establishes within the State Department of Health the Acquired Immune Deficiency Syndrome Institute. The Institute has the responsibility for administering the provisions of this article and coordinating New York State's policies with respect to AIDS. As previously mentioned in Question 4, Health Department regulations require certain individuals to report AIDS or suspected AIDS cases to their agency. Health Department regulations, 10 NYCRR subpart 24-2, prohibit any establishment from making facilities available for purposes of sexual activities in which high risk sexual activity takes place. Such facilities are deemed to constitute a public nuisance dangerous to the public health. Establishment is defined as any place in which entry, membership, goods or services are purchased. High risk sexual activity is deemed as anal intercourse and fellatio. Failure to comply with this regulation may result in closure of the establishment.

Under Section 2307 of the Public Health Law, it is a misdemeanor for anyone knowing himself/herself to be infected with a venereal disease to have intercourse with another individual. Section 2309 entitled "Sexually Transmitted Diseases", makes it a misdemeanor to violate Sections 2300 through 2307 of such law. To date, AIDS has not been classified as a sexually transmitted disease or contagious disease for purposes of Public Health Law statutory framework.

17. Q. SHOULD A VIOLATION OF PROBATION BE INSTITUTED IF A PROBATIONER REFUSES TO RESPOND TO A PROBATION OFFICER'S QUESTION AS TO WHETHER THE PROBATIONER IS HOMOSEXUAL, BISEXUAL, AN INTRAVENOUS DRUG USER, HAS AIDS OR IS A CARRIER?

A. No. While Section 65.10(3)(c) of the Penal Law requires as a mandatory condition of probation that a probationer answer all reasonable inquiries by the probation officer, such questions are highly personal, and generally not relevant to his/her rehabilitation. To violate a probationer for refusal to answer would be in violation of his/her Fifth Amendment rights.

18. Q. SHOULD A VIOLATION OF PROBATION BE INSTITUTED IF AN AIDS VICTIM OR CARRIER ENGAGES IN SEXUAL RELATIONS?

A. In light of the fact that AIDS has not been listed as a sexually transmitted disease by the State Department of Health, an AIDS or ARC probationer who engages in sexual relations would not appear to be in violation of the Public Health Law. Two permissible conditions of probation which may be applicable are "avoiding injurious or vicious habits" and "refraining from frequenting unlawful or disreputable places or consorting with disreputable persons" (Section 65.10(2)(a)(b) of the Penal Law). If these conditions are present, a probation officer may attempt to bring a violation proceeding on these technical grounds. However, it is uncertain whether a violation would be sustained. A probationer may assert that the probation officer is acting arbitrarily and capriciously in singling out the probationer and allegations of discriminatory practice may be raised. It is suggested that AIDS or ARC probationers be counseled about the serious implications for others with whom he/she has intimate contact and to encourage the probationer to disclose his/her disease to such individuals.

19. Q. SHOULD A PROBATION OFFICER TYPICALLY SEEK EARLY DISCHARGE OF ANY PROBATIONER WHO HAS AIDS OR IS A CARRIER?

A. Section 410.90 of the Criminal Procedure Law governs termination of a probation sentence. To recommend early discharge solely because a probationer has AIDS or is a carrier would not be consistent with criteria established in law. Early discharge should only be considered when the probationer has diligently complied with the terms and conditions of the sentence, termination would not jeopardize public safety, and the probationer is no longer in need of guidance, training or other assistance administered through probation supervision. While no similar provision exists in the Family Court Act, the same criteria should be considered.

20. Q. CAN A PROBATIONER BE DENIED EMPLOYMENT OR TERMINATED SOLELY BECAUSE HE/SHE HAS AIDS?

A. Employment can only be denied or terminated if it can be shown that the disease has rendered the individual unable to perform the duties of the position satisfactorily. Any aggrieved probationer should contact the State Division of Human Rights.

# APPENDIX H

## National Institute of Justice Policy Response Protocol for Law Enforcement Agencies

**U.S. Department of Justice**

National Institute of Justice

*National Criminal Justice Reference Service*

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*Box 6000, Rockville, MD. 20850*

Dear Colleague:

AIDS poses a range of complicated and potentially serious problems for law enforcement agencies. However, timely and rational policy choices, regular staff training specific to law enforcement concerns, and careful consideration of possible legal liabilities can minimize the potential effects of AIDS on the delivery of policy services to the public.

In developing policies and procedures, there are key issues that law enforcement agencies should address. However, the manner in which they may be addressed varies depending on the philosophies and legal considerations of each jurisdiction.

Without adopting or advocating a specific posture, the NIJ AIDS Clearinghouse has outlined the key issues that should be reflected in policies and procedures (see attached outline). The Centers for Disease Control recommends precautionary measures such as the use of gloves when exposure to blood is likely and masks with "one-way" airways for CPR for basic hygiene and to minimize the risk of infection with HIV (the AIDS virus). Occupational risks for HIV infection are extremely low. To date, there have been no job-related cases of HIV infection among law enforcement, corrections, or any other public safety personnel.

We have enclosed copies of AIDS and the Law Enforcement Officer: Concerns and Policies Responses which includes policies and procedures from several law enforcement agencies and AIDS Bulletins which explore the issues outlined on the following pages in greater depth.

If you have questions or need further assistance, please call the NIJ AIDS Clearinghouse at 301-251-5500. An information specialist is available to answer questions, refer you to other sources, and suggest publications on AIDS issues as they pertain to criminal justice. You may also request to be placed on the mailing list to receive AIDS-related publications and materials as they become available.

Sincerely,

AIDS Information Specialist
301-251-5500

## National Institute of Justice Policy Response Protocol for Law Enforcement Agencies

I. Training and Education

   A. Frequency--regular training to ensure that the latest information is presented.

   B. Topics--medical, policy, and legal issues--address specific concerns of law enforcement and stress off-the-job as well as on-the-job risks.

   C. Presenters--health officials, practitioners, administrators, and other professionals. It is critical that presenters be knowledgable and credible.

   D. Audience--all recruits and inservice personnel--training should be mandatory.

   E. Format--"live" training with ample time for questions-and-answers with knowledgeable speakers.

   F. Tone--avoid extremes of alarmism and complacency. Clearly and specifically discuss high-risk behavior and exposures.

   G. Evaluation--pre- and post-training questionnaires.

II. Approaches to Policy Response

   A. Follow existing policies for communicable diseases (infection control measures,such as blood and body fluids precautions designed to prevent transmission of Hepatitis-B,should be more than sufficient to prevent transmission of HIV) but incorporate AIDS specific information. Or,

   B. Adopt specific policies and procedures for AIDS.

III. Medical Information
(Current and accurate)

A. Terminology

1. Communicable disease
2. Acquired Immunodeficiency Syndrome (AIDS)
3. AIDS-Related Complex
4. Human Immunodeficiency Virus

B. Modes of transmission (emphasize that HIV is NOT transmitted through casual contact.)

1. Homosexual and heterosexual activity
2. Infected mother to fetus or infant
3. Blood-to-blood exposure
(e.g. needle sharing by intravenous drug users)

IV. Occupational Issues
(The identified areas represent low risk for transmission. Measures are simply precautions recommended by U.S. Public Health, Centers for Disease Control, for basic hygiene.)

A. Assaults, human bites, and other disruptive behavior

1. Milk the wound to make it bleed.
2. Wash the area thoroughly with soap and water.
3. Seek medical attention.

B. Police lockups

1. Provide careful supervision to prevent incidents such as sexual assaults in which the HIV infection may be transmitted.
2. Educate arrestees on high-risk behavior and precautionary measures.

C. Searches and evidence handling—concern for cuts or puncture wounds

1. Use gloves in conducting searches and handling evidence.
2. When possible, have suspects empty their own pockets and handbags.
3. Use mirrors when possible to examine places hidden from direct view.
4. Use puncture-proof containers for evidence.
5. Label potentially infectious materials.

D. CPR and first-aid

1. Use masks or one-way airways for CPR.
2. Keep all cuts or open wounds covered with clean bandages.
3. Wear gloves when exposure to blood is likely.
4. Wash hands after contact.
5. Clean-up spills with 1:10 household bleach solution.

E. Body removal
(Authorized personnel only)

1. Keep all cuts or open wounds covered with clean bandages.
2. Wear gloves.

F. Disposal of protective equipment

1. Label items as potentially infectious.
2. Store in specially marked containers.
3. Dispose of in same manner as infectious materials.

V. Legal and Labor Relations Issues

A. Procedure for reporting incidents in which transmission of HIV infection may have occurred

B. HIV antibody testing

1. Require, recommend, or make available testing for officers and other individuals who may have been involved in incidents in which the HIV infection may have been transmitted.
2. Address issues including informed consent and refusal to be tested, confidentiality, baseline and followup testing, and counseling.

C. Employment status of personnel with asymptomatic HIV infection

D. Employment status of personnel with ARC/AIDS

E. Officers' obligation to perform duties involving HIV-infected individuals (Fear of AIDS is not a legitimate excuse for refusal to perform duties.)

F. Responsibility to prevent HIV transmission

  1. Educate suspects who participate in high-risk behavior.
  2. Supervise prisoners in lockups.

IV. Resources for Education, Training, and Further Information

A. Federal, State, and local agencies

  1. Health officials
     a. U.S. Public Health Service
     b. Centers for Disease Control
     c. Occupational Safety and Health Administration
     d. State and local health departments
  2. State AIDS Coordinator
  3. National Institute of Justice
  4. National Institute of Corrections

B. Criminal justice professional organizations

  1. American Correctional Association
  2. International Association of Chiefs of Police
  3. Police Executive Research Forum
  4. National Sheriffs' Association

C. Community organizations

  1. American Red Cross
  2. Community-based AIDS action groups
  3. Gay and lesbian organizations

**U.S. Department of Justice**
Office of Justice Programs
*National Institute of Justice*

*Washington, D.C. 20531*

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